MEDICAL BENEFIT BOOKLET

For

YP HOLDINGS LLC

UNION YP CONNECTICUT INFORMATION SERVICES LLC
HEALTH SAVINGS ACCOUNT
EFFECTIVE DATE: APRIL 1, 2013

Administered By

Anthem BlueCross BlueShield

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If You need assistance in Spanish to understand this document, You may request it for free by calling Customer Service at the number on Your Identification Card.

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the health care plan (the "Plan") offered by Your Employer. You should read this booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact Your Employer's Group Health Plan Administrator or call the Claims Administrator's Customer Service Department.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The health care services are subject to the Limitations and Exclusions, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

This is a Preferred Provider Organization (PPO) plan for all Members except residents of Georgia and Missouri. Members residing in those states are part of a Point of Service (POS) plan, and must use the appropriate POS Network Provider in their respective states to receive Network benefits. If You are a Member in a state outside of Georgia and Missouri that participates in an Alternate Network arrangement, please call the Customer Service number on Your Identification Card to locate participating providers.

Anthem Blue Cross and Blue Shield, or "Anthem" has been designated by Your Employer to provide administrative services for the Employer's Group Health Plan, such as claims processing, care management, and other services, and to arrange for a network of health care providers whose services are covered by the Plan.

Important: This is <u>not</u> an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Georgia and Missouri. Although Anthem is the Claims Administrator and is licensed in Georgia and Missouri, You will have access to providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

Verification of Benefits
Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Customer Service with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 8:00 p.m. eastern time**). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment.** CALL THE CUSTOMER SERVICE NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.

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YOUR RIGHTS AND RESPONSIBILITIES AS AN ANTHEM BLUE CROSS BLUE SHIELD MEMBER

As an Anthem Blue Cross Blue Shield (Anthem) Member You have certain rights and responsibilities to help make sure that You get the most from your Plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how You work with us and Your doctors. It's kind of like a "Bill of Rights" and helps You know what You can expect from Your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with Your doctors and other health professionals about all health care options and treatment needed for Your condition, no matter what the cost or whether it's covered under Your Plan.
- Work with Your doctors in making choices about Your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to Your personal health information, as long as it follows state and Federal laws, and privacy rules.
- Get information about Anthem's company and services, and Anthem's network of doctors and other health care Providers.
- Get more information about Your rights and responsibilities and give Anthem Your thoughts and ideas about them.
- Give Anthem Your thoughts and ideas about any of the rules of Your health care plan and in the way Your Plan works.
- Make a complaint or file an appeal about:
    - Your health care Plan
    - Any care You get
    - Any Covered Service or benefit ruling that Your health care Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care You may get in the future; and the right to have Your doctor tell You how that may affect Your health now and in the future.
- Participate in matters that deal with the Anthem's policies and operations.
- Get all of the most up-to-date information about the cause of Your illness, Your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that You will not be able to understand certain information, that information will be given to someone else that You choose.

You have the responsibility to:

- Choose any Primary Care Physician (doctor), also called a PCP, who is in our network if Your health care plan says that You have to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with Your health care providers and call their office if You have a delay or need to cancel.
- Read and understand, to the best of Your ability, all information about Your health benefits or ask for help if You need it.
- To the extent possible, understand Your health problems and work with Your doctors or other health care professionals to make a treatment plan that You all agree on.
- Follow the care plan that You have agreed on with Your doctors or health care professionals.
- Tell Your doctors or other health care professionals if You don't understand any care You're getting or what they want You to do as part of Your care plan.
- Follow all health care Plan rules and policies.
- Let Anthem's Customer Service department know if You have any changes to Your name, address or family members covered under Your Plan.

- Give Anthem, the Employer, Your doctors and other health care professionals the information needed to help You get the best possible care and all the benefits You are entitled to. This may include information about other health care plans and insurance benefits You have in addition to Your coverage with the Employer.

For details about Your coverage and benefits, please read Your Benefit Booklet.

The Claims Administrator and Plan are committed to providing quality benefits and customer service to Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance
Anthem is committed to communicating with our members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our Customer Service Call Centers. Simply call the Customer Service phone number on the back of Your ID card and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting customer service.

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the Definitions and Claims Payment sections for more information.

Under certain circumstances, if the Claims Administrator pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

Essential Health Benefits provided under this Plan are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental health and substance use disorder services, including behavioral health treatment,**
- **Prescription drugs,**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Welcome to the Health Savings Account (HSA) Plan!

The HSA plan administered by Anthem is an innovative approach to health benefits for eligible Employees of YP Holdings LLC.

With the HSA plans, You have health coverage available to You for which You and the company share the cost. This coverage has two components designed to work together to provide You flexibility and control in choosing the health care services You and Your family members receive and in choosing how the cost of these services is paid. Bottom line, the plans are designed to help You – and Your family – take control of Your health care dollars and decisions.

How the HSA Plan Works

The HSA plan is an innovative approach to health benefits that puts You in charge of the money You spend for health care services and helps You get the most out of Your company-sponsored health coverage. With the HSA plan, You have flexibility and control in choosing the health care services You and Your family members receive – and in determining how the cost of these services is paid.

The HSA Plan – In Brief

First - **Use Your HSA to pay for Covered Services:**

Health Savings Account
With the Health Savings Account (HSA), You can contribute pre-tax dollars to Your HSA. Others may also contribute dollars to Your account. You can use the dollars to help meet Your annual Deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

Plus – To help You stay healthy, use:
Preventive Care
100% coverage for nationally recommended services.

No deductions from the HSA or Out-of-Pocket costs for You as long as You receive Your preventive care from a Network Provider. If You choose to go to an Out-of-Network Provider, for preventive care, You are responsible for the full cost of the care.

If needed -
Traditional Health Coverage
Traditional Health Coverage is made available by Your Employer on a self-funded basis and helps to protect You and Your family in case You have significant health care expenses. Coverage is effective once You have met an up-front Out-of-Pocket cost for covered expenses (Your Deductible). Once coverage is effective, the Plan will reimburse a percentage of the cost for Covered Services. You will be responsible for covering the remainder of the expense of Covered Services, up to an annual Out-of-Pocket Maximum. After this amount has been met, You will receive coverage for Covered Services for the remainder of the Plan year as specified elsewhere in this Benefit Booklet. The Traditional Health Coverage is governed by the details contained elsewhere in this document.

NOTE: Words and phrases within this document that are denoted with initial capitalization have the meaning ascribed to them within the document itself, or within the Definitions section.

The company reserves the right to amend or terminate the plan at any time. You will be notified of any changes that affect Your benefits, as required by Federal law.

Choice of Providers

The Plan offers discounts to consumers through partnerships with Providers throughout the nation.

Members have automatic access to Provider directories, free of charge, by accessing the member site at www.anthem.com, or by contacting the Anthem Customer Service Department at the phone number listed on Your Identification Card.

With the Plan, You have the flexibility to see any licensed health care provider You choose. The Doctors Plus Directory can help You locate a Provider near You. The level of Your health coverage under the Plan depends on whether You use Providers who offer Network discounts or Providers who do not offer Network discounts.

Financial Tools

Each plan offers online financial tools to help You keep track of Your health care dollars. Plus You can track Your claims for Covered Services. You can review what You've spent on health care, view Your balance, or look up the status of a particular claim any time of the day.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum

Allowable Amount, which is the maximum amount the Plan will pay for a given service. When You use an Out-of-Network Provider, You are responsible for any balance due between the Out-of-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Deductibles, and non-covered charges.

Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

Contributions to Your HSA

For 2013, contributions can be made to Your HSA up to the following:

Contributions to Your HSA	
Individual Coverage	$3,250
Family Coverage	$6,450

Note: These limits apply to all combined contributions from any source, except rollover funds.

Annual Deductible Responsibility:

Deductible	**Network**	**Out-of-Network**
Individual Coverage	$1,250	$2,500
Family Coverage	$2,500	$5,000

Note: All medical and Prescription Drug Coinsurance is subject to the Deductible and apply to the Out-of-Pocket Maximum. The Family Deductible must be satisfied by either one Member or all Members collectively before any Covered Services are paid by the Plan except for services with no Coinsurance.

Coinsurance

Traditional Health Coverage Coinsurance	**Network**	**Out-of-Network**
The Plan Pays	85%	60%
Your Coinsurance Responsibility	15%	40%

Out-of-Pocket Maximum

The plan's Out-of-Pocket Maximum is the most that You will pay toward covered health expenses in a Plan year. Once You reach the Out-of-Pocket Maximum under the plan, the Plan pays 100% of Covered Services for Providers who offer discounts and 100% of Maximum Allowed Amount charges for Providers who do not offer discounts.

Annual Out-of-Pocket Maximum	**Network**	**Out-of-Network**
Individual Coverage	$3,000	$6,000
Family Coverage	$6,000	$12,000

Note: The Out-of-Pocket Maximum includes all Deductibles and/or Coinsurance You incur in a Benefit Period. Once the Family Out-of- Pocket Limit is satisfied, no additional Coinsurance will be required for the Family for the remainder of the Benefit Period except for Out-of-Network Human Organ and Tissue Transplant services.

Benefits	Network	Out-of-Network
Allergy Care		
• Testing • Treatment • Serum and allergy shots	85% 85% 85%	60% 60% 60%
Behavioral Health/Substance Abuse Care		
• Hospital Inpatient Services • Outpatient Services • Physician Services (Home and Office Visits)	85% 85% 85%	60% 60% 60%
Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.		
Contraceptive – services not included in Women's Health Provision • Contraceptives not included in Women's Health Provision, including but not limited to: spermicide, vaginal ring, hormone patch, Depo-Estradiol Cypionate – up to 5 MG and other covered contraceptives included in Women's Health provision but not meeting required Women's Health diagnosis restrictions. **Note:** Covered for birth control as well as medical conditions	85%	60%
Contraceptives – covered under Women's Health Provision • IUDs, injections for Depo-Provera, diaphragm fittings, and any other FDA approved birth control devices (other than the ones listed above as not included in Women's Health). **Note:** Covered based on the diagnosis restriction within the Women's Health Provision	100%, no deductible	Not Covered
Dental, Oral Surgery &TMJ Services		
• Accidental Injury to natural teeth (treatment must be completed within 12 months of the Injury)	85%	60%
• Oral Surgery	85%	60%
• TMJ - Subject to Medical Necessity – excludes appliances and orthodontic treatment. Surgical and Non-Surgical procedures are covered	85%	60%

Benefits	Network	Out-of-Network
Diagnostic Physician's Services		
Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:		
• Primary care Physician	85%	60%
• Specialist Physician	85%	60%
• Diagnostic X-ray and Lab – office or independent lab	85%	60%
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Room, Urgent Care, and Ambulance Services		
• Emergency room for an Emergency Medical Condition	85%	(See note below)
• All other services	85%	(See note below)
• Emergency room for a Non - Emergency Medical Condition	85%	60%
• All other services	85%	60%
• Urgent Care clinic visit	85%	60%
• All other services	85%	60%
• Ambulance Services (when Medically Necessary) Land / Air	85%	(See note below)
Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		

Benefits	Network	Out-of-Network
Eye Care		
• Office visit – medical eye care exams (treatment of disease or Injury to the eye)	85%	60%
• Treatment other than office visit	85%	60%
Hearing Care		
• Office visit – Audiometric exam / hearing evaluation test	85%	60%
• Cochlear Implants	85%	60%
• Hearing devices/hearing aids – limited to one hearing aid per ear per 36 months	85%	60%
Routine hearing exams are not a Covered Service.		
Home Health Care Services	85%	60%
• Maximum Home Care visits (does not apply to Private Duty Nursing benefit)	Limited to 120 visits per calendar year, combined in and out of network	
• Maximum Private Duty Nursing	None	
Hospice Care Services	85%	60%
Maximum Hospice Care Services	None	
Hospital Inpatient Services – Precertification Required		
• Room and board (Semiprivate or ICU/CCU)	85%	60%
• Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical Therapy, etc.)	85%	60%
• Inpatient Medical Rehabilitation – limited to 30 days per calendar year combined in and out-of-network	85%	60%
• Pre-Admission testing	85%	60%
• Physician Services:		
► Surgeon	85%	60%
► Anesthesiologist	85%	60%
► Radiologist	85%	60%
► Pathologist	85%	60%
*Anesthesiologist, radiologist, and pathologist charges		

Benefits	Network	Out-of-Network
are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services**. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges**.		
Maternity Care & Other Reproductive Services (includes coverage for female dependent child maternity care)		
Global care (includes pre-and post-natal, delivery)		
• Primary care Physician (includes obstetrician and gynecologist)	85%	60%
• Specialist Physician	85%	60%
• Midwife (Precertification required)	85%	60%
Physician Hospital / Birthing Center Services (Precertification required)		
• Physician's services	85%	60%
• Newborn nursery services (well baby care)	85%	60%
• Circumcision	85%	60%
Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified		
Infertility Services		
• Diagnostic and Treatment of an underlying medical condition	85%	60%
• **$20,000 Medical Lifetime Maximum** (combined in and out of network :In-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.		
Sterilization Services (Precertification required for Inpatient procedures)		
• Vasectomy	85%	60%
Note: Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section in Benefits for further details.		

Benefits	Network	Out-of-Network
Medical Supplies and Equipment • Medical Supplies • Durable Medical Equipment • Orthotics (Foot and Shoe) • Prosthetic Appliances (external) – Wigs and Toupees are covered	 85% 85% 85% 85%	 60% 60% 60% 60%
Nutritional Counseling for Diabetes	85%	60%
Outpatient Hospital/Facility Services • Outpatient facility • Lab and x-ray services • Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.) *Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing in network outpatient services**. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges**.	 85% 85% 85%	 60% 60% 60%
Physician Services (Home and Office Visits) • Primary care Physician • Specialist Physician	 85% 85%	 60% 60%
Office Surgery	85%	60%
Prescription Injectables / Prescription Drugs Dispensed in the Physician's Office	85%	60%
Prescription drugs (retail and mail order)	Administered by Express Scripts	
Preventive Services (regardless of Provider or setting where Preventive care is provided) **Note: Preventive Services are defined as any claim submitted with a "well" diagnosis.**	100%, deductible does not apply	Not Covered
Skilled Nursing Facility (precertification required) • Maximum Skilled Nursing Benefit	85% None	60%

Benefits	Network	Out-of-Network
Surgical Services **Note:** Assistant Surgeon – Out-of-Network services performed in conjunction with a Network Surgeon are covered at the Network deductible and coinsurance at the Local plan allowance.	85%	60%
Gastric Bypass/Obesity/Bariatric Surgery When Medically Necessary. Precertification Required	85%	60%
Therapy Services (Outpatient)		
• **Physical Therapy** (30 visits per calendar year combined in and out-of-network)	85%	60%
• **Occupational Therapy** (30 visits per calendar year combined in and out-of-network)	85%	60%
• **Speech Therapy** (30 visits per calendar year combined in and out-of-network)	85%	60%
• **Cardiac Rehabilitation**	85%	60%
• **Chiropractic Care** (20 visits per calendar year combined in and out-of-network)	85%	60%
• **Radiation Therapy**	85%	60%
• **Chemotherapy**	85%	60%
• **Respiratory Therapy**	85%	60%
• **Vision Therapy**	85%	60%
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Transplants Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, including Medically Necessary preparatory myeloablative therapy. **The Center of Excellence requirements do not apply to** Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **Note:** Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)	**Center of Excellence/Network Transplant Provider**	**Out-of-Network Transplant Provider**

Benefits	Network	Out-of-Network
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Customer Service number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)	Not Covered
• **Covered Transplant Procedure during the Transplant Benefit Period**	Blue Distinction Center of Transplant (BDCT) facility: 100% Network Provider: 85%	60%
• **Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)**	Blue Distinction Center of Transplant (BDCT) facility: 100% Network Provider: 85%	60%
• **Bone marrow Donor Search Fee (Unrelated Family Member only)** - limited to a $30,000 per search	Blue Distinction Center of Transplant (BDCT) facility: 100% Network Provider: 85%	60%

Benefits	Network	Out-of-Network
• **Eligible Travel and Lodging –** $10,000 per Transplant. Unlimited Lodging allowance. $5,000 combined lifetime max for air ambulance/airfare to patient's family member or donor's family member (no limit for patient or donor).	100%, no deductible	60%
• **All Other Covered Transplant Services**	Blue Distinction Center of Transplant (BDCT) facility: 100% Network Provider: 85%	60%

ELIGIBILITY

Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Coverage for the Employee

This Benefit Booklet describes the benefits an Employee may receive under this health care Plan. The Employee is also called a Subscriber.

Coverage for the Employee's Dependents

If the Employee is covered by this Plan, the Employee may enroll his or her eligible Dependents. Covered Dependents are also called Members.

Eligible Dependents Include:

- The Employee's Spouse or Domestic Partner. For the purposes of this Plan, a Spouse is defined as a person who is married to a person of the opposite sex from the enrolling Employee.
- Domestic Partner status shall exist between two persons regardless of their gender and each of them shall be the domestic partner of the other if they:
    - Are both at least age 18;
    - Neither is legally married to another person or in a domestic partnership or civil union with another person that has not been terminated, dissolved, or annulled;
    - Are not related by blood to a degree of closeness that would prohibit marriage;
    - Are in an exclusive, committed relationship that is intended to be permanent;
    - Share a mutual obligation of support and responsibility for each other's welfare;
    - Currently share a principal residence and intend to do so indefinitely; and
    - Both individuals are capable of consenting to the domestic partnership.
- The Employee's children, legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren, until the end of the month in which they attain age 26. Also included are the Employee's children (or children of the Employee's Spouse or Domestic Partner) for whom the Employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the Employee for support, regardless of age, with the exception of incapacitated children age 26 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Plan or have prior Creditable Coverage prior to reaching age 26. Certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically.

Initial Enrollees

Initial Enrollees and eligible Dependents who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Any Employer waiting period which was not satisfied under previous Creditable Coverage must be satisfied under this Plan. However, credit will be given for the length of time already served.

New Hires

Applications for enrollment must be submitted within 31 days from the date an Employee is eligible to enroll as set by the Employer. Applications for membership may be obtained from the Employer. Coverage will be effective based on the waiting period chosen by the Employer. If the Employee or the Employee's Dependents do not enroll when first eligible, the Employee or the Employee's Dependents will be treated as Late Enrollees. Please refer to the "Late Enrollees" provision listed below.

Late Enrollees

If the Employee or the Employee's Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, the Employee or the Employee's Dependents may be eligible for special enrollment as set out below.

Special Enrollment Periods

There are special enrollment periods for Employees or Dependents who:

- Originally declined coverage because of other coverage, and
- Exhausted COBRA benefits, lost eligibility for prior coverage, or Employer contributions toward coverage were terminated.
- A full list of qualified life events can be found in the Wrap SPD

An individual who declined coverage must have certified in writing that he or she was covered by another health plan when he or she initially declined coverage under this Plan in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births or adoptions or placement for adoption. An unenrolled Member may enroll within 31 days of such a special qualifying event.

Important Notes:

- Individuals enrolled during special enrollment periods are **not** Late Enrollees.
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
- Evidence of prior Creditable Coverage is required and must be furnished by the Employee or the Employee's prior carrier.

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Coverage Begins

If the Employee applies for coverage when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires.

Changing Coverage

There will be an annual re-enrollment period during which time Members may elect to change their options. Employees and Dependents enrolled in another option may be required to complete an unfulfilled waiting period from prior Creditable Coverage.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

Changing Coverage (Adding a Dependent)

You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Employee has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

Marriage and Stepchildren

An Employee may add a Spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If an Employee does not apply for coverage to add a Spouse and stepchildren within 31 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the **"Late Enrollees"** provision in this section.

Newborn and Adopted Children

You must contact Your Employer within 31 days to add a newborn or adopted child.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final.
  - An "adopted child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received an MCSO (a "Medical Child Support Order") which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order ("QMCSO").
  - Upon receipt of an MCSO, the Employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Family and Medical Leave

If a covered Employee ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Coverage or Removing a Dependent

When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- Divorce; Domestic Partner dissolution;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches age 26 (see "When Coverage Terminates");
- Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work

Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer but not currently active due to health status.

Portability Provision

Any newly eligible Employee, Member, enrollee or Dependent who has had similar coverage under another health benefit plan within the previous 63 days is eligible for coverage immediately. The Effective Date of coverage is subject to any length-of-service provision the Employer requires. A newly eligible person is an individual who was not previously eligible for coverage under this Plan. Pre-Existing exclusions are not applicable to Members under the age of 19.

SUMMARY OF BENEFITS

Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the "Definitions" Section.

Introduction

Your health Plan is a Preferred Provider Organization (PPO) for all Members except residents of Georgia and Missouri are part of a Point of Service (POS) plan. The Plan is divided into two sets of benefits: Network and Out-of-network. If You choose a Network Provider, You will receive Network benefits. **Members who are residents of Georgia and Missouri, must use the appropriate POS Network Provider in their respective states to receive Network benefits.** Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

BlueCard® PPO Program

Nationwide, Blue Cross and Blue Shield plans have established Preferred Provider Organization (PPO) networks of physicians, hospitals, and other healthcare providers. As a PPO member **(or POS member if You are a resident of Georgia and Missouri)**, You have access to these networks through the BlueCard PPO Program. The suitcase logo on Your I.D. card indicates that You are a member of the BlueCard PPO Program. Visit www.bcbs.com, and select the "PPO/EPO" network; or call the Customer Service number on Your Identification Card to locate participating providers.

The BlueCard program helps reduce Your costs when You access covered Out-of-Network care throughout the United States (to receive Network benefits, You must use a provider in the BlueCard PPO program). Simply show Your Identification Card with the PPO in a suitcase logo, and You will benefit from discounts that these BlueCard providers have agreed to extend to their local Blue Cross and/or Blue Shield plan. Be sure to verify that the provider participates in the BlueCard Program. To do so, visit www.bcbs.com and select the "Traditional/Indemnity" network. Services rendered by these providers will be considered Out-of-Network, but will generally cost less than services provided by other Out-of-Network Providers.

Care Outside the United States – BlueCard® Worldwide

Prior to travel outside the United States, check with Your Group or call Customer Service at the number on your Identification Card to find out if Your Plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we recommend:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your current Identification Card.
- In an emergency, go directly to the nearest Hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- You need to find a Physician or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.
- You need to be hospitalized or need Inpatient care. After calling the Service Center, You must also call the Claims Administrator to obtain approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information

- **Participating BlueCard Worldwide Hospitals.** In most cases, when You make arrangements for hospitalization through BlueCard Worldwide, You should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the Out-of-Pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) You normally pay. The Hospital should submit Your claim on Your behalf.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then You can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged Your hospitalization. You will need to pay the Hospital for the Out-of-Pocket costs You normally pay.
- You must file the claim for outpatient and Physician care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

Claim Forms

International claim forms are available from the Claims Administrator, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.

Calendar Year Deductible

Before the Plan begins to pay benefits, You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits.**

HEALTH CARE MANAGEMENT - PRECERTIFICATION

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to determine when services should be covered by Your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior Authorization: Network Providers are required to obtain prior authorization in order for You to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Claims Administrator may determine that a service that was initially prescribed or requested is not Medically Necessary if You have not previously tried alternative treatments which are more cost effective.

If You have any questions regarding the information contained in this section, You may call the Customer Service telephone number on Your Identification Card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, You, Your authorized representative or Physician must notify the Claims Administrator within 2 business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. The Claims Administrator will review Your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

Post Service Clinical Claims Review– A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Failure to Obtain Precertification Penalty:

IMPORTANT NOTE: IF CLAIMS ARE NOT PRE-CERTIFIED THEY WILL BE REJECTED FOR NO PRE-CERTIFICATION. ONCE INFORMATION IS RECEIVED CLAIMS CAN BE RE-OPENED BASED ON MEDICAL INFORMATION PROVIDED. A NON-COMPLIANCE PENALTY (FAILURE TO OBTAIN PRE-CERT) OF $500 FOR NON-PARTICIPATING HOSPITALS OR RESIDENTIAL TREATMENT ADMISSIONS (EXCEPT FOR MATERNITY SERVICES OR MASTECTOMY AND LYMPH NODE DISSECTION) IS ASSESSED ON THE MEMBER'S CLIAMS.

The following list is not all inclusive and is subject to change; please call the Customer Service telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

Inpatient Admission:

- All acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehabilitation, and Obstetrical delivery stays beyond the 48/96 hour Federal mandate length of stay minimum (including newborn stays beyond the mother's stay)
- Emergency Admissions (requires Plan notification no later than 2 business days after admission)

Outpatient Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance (does not include 911 initiated emergency transport)
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bariatric surgery
- Bone-Anchored Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction, Mastectomy for Gynecomastia and other Breast Procedures
- Canaloplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation
- Diagnostic Testing
    - Diagnosis of Sleep Disorders
    - Gene Expression Profiling for Managing Breast Cancer Treatment
    - Genetic Testing for Cancer Susceptibility
- DME/Prosthetics
    - Bone Growth Stimulator: Electrical or Ultrasound
    - Communication Assisting / Speech Generating Devices
    - External (Portable) Continuous Insulin Infusion Pump Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
    - Microprocessor Controlled Lower Limb Prosthesis
    - Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
    - Pneumatic Pressure Device with Calibrated Pressure
    - Power Wheeled Mobility Devices
    - Prosthetics: Electronic or externally powered and select other prosthetics
    - Standing Frame
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation

- Implantable or Wearable Cardioverter-Defibrillator (ICD)
- Implantable Infusion Pumps
- Implantable Middle Ear Hearing Aids
- Implanted Devices for Spinal Stenosis
- Implanted Spinal Cord Stimulators
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar spinal surgeries
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
- Surgical Treatment of Migraine Headaches
- Occiptal nerve stimulation
- Orthognathic Surgery
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Back Pain
- Photocoagulation of Macular Drusen
- Physician Attendance and Supervision of Hyperbaric Oxygen Therapy
- Plastic/Reconstructive surgeries:
    - Abdominoplasty, Panniculectomy, Diastasis Recti Repair
    - Blepharoplasty
    - Brachioplasty
    - Buttock/Thigh Lift
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Insertion/Injection of Prosthetic Material Collagen Implants
    - Liposuction/Lipectomy
    - Procedures Performed on Male or Female Genitalia
    - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
    - Procedures Performed on the Trunk and Groin
    - Repair of Pectus Excavatum / Carinatum
    - Rhinoplasty
    - Skin-Related Procedures
- Percutaneous Spinal Procedures
- Private Duty Nursing
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Radiation therapy
    - Intensity Modulated Radiation Therapy (IMRT)
    - Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis

- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Thoracoscopy for Treatment of Hyperhidrosis
- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Preventicular Device
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment
- Wearable Cardioverter Defibrillators

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admissions for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- All Outpatient services for the following:
    - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
    - Donor Leukocyte Infusion

Mental Health/Substance Abuse (MHSA):

Pre-certification Required

- Acute Inpatient Admissions
- Electric Convulsive Therapy (ECT)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)

Outpatient Therapy

- May be required after the initial twelve (12) visits. Please call the customer service number on Your ID card for details.

Referrals:

Requests for Out of Network Referrals for care that the Claims Administrator determines are Medically Necessary may be pre-authorized, based on network adequacy.

Utilizing a Provider outside of the Network may result in significant additional financial responsibility for You, because Your health benefit plan cannot prohibit Out-of-Network Providers from billing You for the difference between the Provider's charge and the benefit the Plan provides.

The ordering Provider, facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification?	
Services provided by a Network Provider, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.	**Services provided by BlueCard providers outside the service areas of the states listed in the column to the left, BlueCard providers in other states not listed, and any Out-of-Network/Non-Participating Provider.**
Provider is responsible for Precertification.	• Member is responsible for Precertification. • Member is financially responsible for service and/or setting that are not covered under this Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative.

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making Medical Necessity decisions. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Employer's Group Health Plan Document takes precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to Your request. To request this information, contact the Customer Service telephone number on Your Identification Card.

The Claims Administrator may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in the Claims Administrator's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, the Claims Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt Your claim from medical review if certain conditions apply.

Just because the Claims Administrator exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that the Claims Administrator will do so in the future, or will do so in the future for any other Provider, claim or Member. The Claims Administrator may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by contacting the customer service number on the back of your ID card.

Request Categories:

- **Urgent –** a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective –** a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent -** a request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective -** a request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements
Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on Your Identification Card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make a decision, the Claims Administrator will notify the requesting Provider and send written notification to You or Your authorized representative of the specific information necessary to complete the review. If the Claims Administrator does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in the Claims Administrator's possession.

The Claims Administrator will provide notification of its decision in accordance with federal regulations.

Notification may be given by the following methods:

> **Verbal:** oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.
> **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Member or authorized Member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date You receive service:

1. You must be eligible for benefits;
2. the service or surgery must be a covered benefit under Your Plan;
3. the service cannot be subject to an exclusion under Your Plan, including but not limited to a Pre-Existing Condition limitation or exclusion; and
4. You must not have exceeded any applicable limits under Your Plan.

Care Management

Care Management is a Health Care Management service designed to help promote the timely coordination of services for Members with health care related needs due to serious, complex, and/or chronic medical conditions. The Claims Administrator's Care Management programs coordinate health care benefits and available services to help meet health-related needs of Members who are invited and agree to participate in the Care Management Program.

Care Management programs are confidential and voluntary. These programs are provided at no additional cost to You and do not affect Covered Services in any way. Licensed health care professionals trained in care management and familiar with the benefit plan provide these services.

For Members who meet program requirements/criteria and who agree to participate in a Care Management program, a licensed health care professional completes an assessment and develops an individualized plan designed to help meet their identified health care related needs. This is achieved through communication, and collaboration with the Member and/or Member's designated representative, treating Physician(s), and other Providers. The licensed health care professional remains in contact with the Member by telephone on a periodic basis to help accomplish the goals of the plan.

In addition to coordinating benefits, the licensed health care professional may assist with coordination of care with existing community-based programs and services to meet the Member's needs. Care coordination may include referrals to external agencies and available community-based programs and services.

BENEFITS

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details.

All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

Ambulance Service
Local service to the closest appropriate Hospital in connection with care for a Medical Emergency or if otherwise Medically Necessary. Such service also covers Your transfer from one Hospital to another if Medically Necessary. Air ambulance is covered subject to Medical Necessity.

Assistant Surgery
Services rendered by an assistant surgeon are covered based on Medical Necessity.

Behavioral Health Care and Substance Abuse Treatment
See the Schedule of Benefits for any applicable Deductible and Coinsurance information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or Outpatient basis will not be subject to Deductibles or Coinsurance provisions that are less favorable than the Deductibles or Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Hospital Inpatient Care

Benefits for Inpatient Hospital and Physician charges are Covered Services.

Professional Outpatient Care

Covered Services include:

- Professional care in the Outpatient department of a Hospital;
- Physician's office visits; and
- Services within the lawful scope of practice of a licensed, approved provider.

Residential Treatment

Benefits also include services for Substance Abuse Residential Treatment which is specialized 24 hour care that occurs in a licensed Residential Treatment Center (RTC) or intermediate care facility. It offers individualized and intensive treatment in a residential setting and includes:

- observation and assessment by a psychiatrist weekly or more frequently
- an individualized program of rehabilitation, therapy, education, and recreational or social activities in compliance with existing law

Residential treatment provides an intermediate-term approach to treatment that attempts to return the patient to the community.

Note: To be reimbursable, care must be given by a psychiatrist, psychologist, neuropsychologist, or a mid-level provider such as a licensed clinical social worker, mental health clinical nurse specialist, a marriage and family therapist, or a licensed professional counselor.

Breast Cancer Care
Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be

conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

Breast Reconstructive Surgery

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Cardiac Rehabilitation

Covered Services are provided as outlined in the **Schedule of Benefits.**

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Plan.

Dental Services

Related to Accidental Injury

Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury.

"Initial" dental work to repair injuries due to an accident means performed within 12 months from the Injury or within 12 months of the Member's Effective Date. Treatment must be completed within 12 months of the accident.

Other Dental Services

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- The Member is under the age of five (5);
- The Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes

Equipment and Outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

Durable Medical Equipment

This Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the Member's physical disorder.

Emergency Services

Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care including a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any prior authorization from the Plan.

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method the Claims Administrator generally uses to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

The Coinsurance percentage payable for both Network and Out-of-Network are shown in the Schedule of Benefits.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce Outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Member must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan as described.
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse.
- Any services for any period during which the Member is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member.
- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.
- Dietician services.
- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.

Hospice Care Services

Hospice benefits cover Inpatient and Outpatient services for patients certified by a Physician as terminally ill with a life expectancy of six months or less.

Your Plan provides Covered Services for Inpatient and Outpatient Hospice care as stated in the **Schedule of Benefits**. The Hospice treatment program must:

- Be recognized as an approved Hospice program by the Claims Administrator;
- Include support services to help covered family members deal with the Member's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
  - provides an organized system of home care;
  - uses a Hospice team; and
  - has around-the-clock care available.

To qualify for Hospice care, the attending Physician must certify that the Member is not expected to live more than six months. Also, the Physician must design and recommend a Hospice Care Program.

Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

Network

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent Semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **"Schedule of Benefits"** section.

Outpatient Hospital Services

The Plan provides Covered Services when the following Outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

Human Organ and Tissue Transplant Services

Notification

The Plan strongly encourages the Member to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the customer service telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or benefit booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Claims Administrator for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Network Transplant Provider Facility.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Licensed Speech Therapist Services

Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits.** Speech Therapy is not covered when rendered for the treatment of Developmental Delay.

Maternity Care & Infertility Services

Covered Services are provided for Network Maternity Care subject to the cost share stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Maternity benefits are provided for a female Employee, female Spouse or female Domestic Partner of the Employee only.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.)

Under federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Member's attending Physician.

Abortion (Therapeutic or Elective) - Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape. Your Plan also provides benefits for an elective (voluntary) abortion, which is an abortion performed for reasons other than those described above.

Infertility Services
Your Plan also includes benefits for the diagnosis and treatment of an underlying medical condition. Covered Services include diagnostic and exploratory procedures to determine whether a Member suffers from Infertility. This includes surgical procedures to correct any diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. See the **Schedule of Benefits** for benefit limitations and Coinsurance amounts.

Medical Care
General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

Nutritional Counseling
Nutritional counseling related to the medical management of a disease state as stated in the **Schedule of Benefits**.

Out-of-Network Freestanding Ambulatory Facility
Any services rendered or supplies provided while You are a patient or receiving services at or from a Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

Out-of-Network Hospital Benefits
If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **"Schedule of Benefits"** section.

Obesity
Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan. Precertification is required, and coverage is only provided for gastric bypass, vertically banded gastroplasty and adjustable gastric banding procedure (lap band) as stated on the Schedule of Benefits.

Oral Surgery
Covered Services include only the following:
- Fracture of facial bones;
- Removal of impacted teeth;
- Lesions of the mouth, lip, or tongue which require a pathological exam;

- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan and performed within 180 days after the accident.

Other Covered Services

Your Plan provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, splints, casts when provided by a Physician
- Oxygen, blood and components, and administration
- Pacemakers and electrodes
- Use of operating and treatment rooms and equipment

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Outpatient Surgery

Network Hospital Outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. These benefits are subject to both Deductible and percentage payable (Coinsurance) requirements. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services”.

Physical Therapy, Occupational Therapy, Chiropractic Care

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the **Schedule of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual provider. No coverage is available when such services are necessitated by Developmental Delay.

Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements.

Preventive Care

Preventive Care services include Outpatient services and office services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Plan with no Deductible, Coinsurance from the Member when provided by a Network Provider. That means the Plan pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

   a. Breast cancer;
   b. Cervical cancer;
   c. Colorectal cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

   a. Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.

   b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per calendar year.

   c. Gestational diabetes screening.

You may call Customer Service using the number on Your ID card for additional information about these services. (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.)

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are **excluded:** corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

Reconstructive Surgery

Precertification is required. Reconstructive surgery does not include any service otherwise excluded in this Benefit Booklet. (See "Limitations and Exclusions.")

Reconstructive surgery is covered only to the extent Medically Necessary:
- to correct significant anatomic deformities which are not within normal anatomic variation and which are caused by congenital or developmental abnormalities, illness, or Injury for the purpose of improving the significant anatomic deformity toward a normal appearance; or
- to correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Retail Health Clinic
Benefits are provided for Covered Services received at a Retail Health Clinic.

Skilled Nursing Facility Care
Benefits are provided as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:
- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:
- semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:
- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Surgical Care
Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

Treatment of Accidental Injury in a Physician's Office

All Outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit and are subject to Deductible and Coinsurance requirements.

LIMITATIONS AND EXCLUSIONS

ACT OF WAR/MILITARY DUTY
Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities as required by law.

CUSTODIAL/CONVALESCENT CARE
Services for Custodial Care.

Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.

DENTAL SERVICES
Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered.

ELIGIBILITY
Charges for treatment received before coverage under this option began or after it is terminated.

EXPERIMENTAL/INVESTIGATIVE
Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are in our judgment, Experimental or Investigative for the diagnosis for which the Participant is being treated.

Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.

FOOT CARE
Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.

Shoe inserts, orthotics (will be covered if prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary).

GOVERNMENT AGENCY/LAWS/PLANS
Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Member has enrolled Medicare Part B.

Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.

MEDICATIONS
Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Although coverage for Outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a Hospital, in a Physician's Office or as part of a Home Health Care benefits. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during a inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.

Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.

MEDICALLY NECESSARY
Care, supplies, or equipment not Medically Necessary, as determined by us, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

Vitamins, minerals and food supplement, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.

Services for Hospital confinement primarily for diagnostic studies.

Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury or to correct a congenital defect.

MISCELLANEOUS
Donor Search/Compatibility Fee (except as otherwise indicated on the Plan Design).

Hearing aids, hearing devices or examinations for prescribing or fitting them.

Contraceptive Drugs, unless otherwise stated by the Plan.

In-vitro Fertilization and Artificial Insemination.

Hair transplants, hair pieces or wigs, wig maintenance, or prescriptions or medications related to hair growth.

Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis or educational interventions, except as expressly provided under "Covered Services".

Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

Christian Science Practitioner.

Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products.

Services provided in a Residential Treatment Center (RTC).

Services provided in a Halfway House.

Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state, or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.

ROUTINE CARE
Routine care is not covered. Except for above stated covered preventative care services.

SPECIAL CHARGES/SERVICES
Services or supplies provided by a member of your family or household.

Charges or any portion of a charge in excess of the maximum allowable amount as determined by the Claims Administrator.

Fees or charges made by an individual, agency or facility operating beyond the scope of its license.

Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.

Services for any form of telecommunication.

Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provider their test results; specific medical reports including those not directly related to the treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.

Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.

SURGERY

Charges for or related to sex change surgery or to any treatment of gender identity disorders.

Reversal of vasectomy or tubal ligation.

Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.

THERAPIES
Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.

VISION CARE
Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, ie diabetes.

Vision Surgeries - Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

WEIGHT REDUCTION PROGRAMS
Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

SMOKING CESSATION TREATMENT
Smoking Cessation Treatment: Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.

Note: Smoking Cessation Counseling is covered per Health Care Reform Preventive Care Services: Intervention services as part of a full physical exam or periodic check-up for the purpose of education or counseling on potential health concerns, including smoking cessation counseling.

CLAIMS PAYMENT

Network Providers have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the Network Hospitals, Physicians and Ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by contacting Your local Human Resources Department or by visiting www.anthem.com.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to the Claims Administrator.

How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within 12 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan. **Residents of Georgia and Missouri must use POS Network Providers.**

When You receive Covered Services from a Network Physician or other Network licensed health care provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from Your Employer or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Maximum Allowed Amount

General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this/Your Plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the BlueCard section for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and

- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status
The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this/Your Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and

Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this/Your Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out of Pocket costs to You. Please call Customer Service for help in finding a Network Provider or visit the Claims Administrator's website at www.anthem.com.

Customer Service is also available to assist You in determining this/Your Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out of Pocket responsibility. Although Customer Service can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

Member Cost Share
For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this Benefit Booklet for Your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Booklet and services

received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. **If services are performed by Out-of-Network Providers,** then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact the Claims Administrator for more information.

Processing Your Claim

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary Information

In order to process Your claim, the Claims Administrator may need information from the provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;
- the amount for which You are responsible (if any); and
- general information about Your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare services outside of Anthem's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem's service area, You will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from nonparticipating healthcare Providers. Anthem's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when You access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever You access covered healthcare services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for Your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If any state laws mandate other liability calculation methods, including a surcharge,

we would then calculate Your liability for any covered healthcare services according to applicable law.

If You obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If You see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and You may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on Your ID card or go to www.anthem.com for more information about such arrangements.

Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Assignment

You authorize the Claims Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The Claims Administrator also reserves the right to make payments directly to You. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Claims Administrator will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Customer Service Department. Be sure to always give Your Member Identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call the Claims Administrator.

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by an employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of Your new address.

YOUR RIGHT TO APPEAL

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which You have not received the benefit or for which You may need to obtain approval in advance. Refer to the provisions regarding Precertification on pages 21-26 for additional details.
- A post-service claim is any other claim for benefits under the plan for which You have received the service.

If Your claim is denied or if Your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA if You appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist You

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify You or Your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the

Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the *Member* or the *Member's authorized representative*, except where the acceptance of oral *appeals* is otherwise required by the nature of the *appeal* (e.g., urgent care). You or Your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 54159, Los Angeles, CA 90054

You must include Your Member Identification Number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

The Claims Administrator will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide You, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided
When the Claims Administrator considers Your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the

treatment is experimental, investigative, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal
If You appeal a claim involving urgent/concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

If You appeal a post-service claim, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

Appeal Denial
If Your appeal is denied, that denial will be considered an adverse benefit determination.The notification from the Claims Administrator will include all of the information set forth in the above section entitled “Notice of Adverse Benefit Determination.”

Voluntary Second Level Appeals
If You are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If You would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review
If the outcome of the mandatory first level appeal is adverse to You and it was based on medical judgment, You may be eligible for an independent External Review pursuant to federal law.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

A request for a External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal. However, You are encouraged to submit any additional information that You think is important for review.

For pre-service claims involving urgent/concurrent care, You may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator’s internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator’s decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To proceed with an Expedited External Review, You or Your authorized representative must contact the Claims Administrator at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider’s name;

- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 54159, Los Angeles, CA 90054

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this health care plan. There is no charge for You to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a lawsuit
No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If Your health benefit plan is sponsored by Your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance and Deductible under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles and Coinsurance, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because You have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary high-deductible health plan’s Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then
        - The Plan covering the spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the

parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering You as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as an employee or as a retired employee and is covered under his or her own Plan as an employee, member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree).

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6 - If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN
When a Member is covered under two or more Plans which together pay more than the Allowable expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is primary. However, when this Plan is secondary under the Order of Benefit Determination Rules, we start with this Plan's Allowable expense, deduct the Primary Plan's payment and then deduct any Deductibles, Coinsurance or Copayments.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:
1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

WHEN A COVERED PERSON QUALIFIES FOR MEDICARE
Determining Which Plan is Primary
To the extent permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:
- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare
If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained and You have a right to a Recovery or have received a Recovery from any source.

Recovery
A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, workers’ compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation
The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement
If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan’s rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
    1. the amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
    2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal Injury or illness to You occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal Injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

GENERAL INFORMATION

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Claims Administrator by the Employer, and any and all statements made to the Employer by the Claims Administrator, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Circumstances Beyond the Control of the Plan

The Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of Your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the customer service number on Your Identification Card.

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent employer liability or indemnification law.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such

benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Medicare Program

When You are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payor, the benefits described in this Benefit Description will be reduced by the amount of benefits allowed under Medicare for the same *Covered Services*. This reduction will be made whether or not You actually receive the benefits from Medicare. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

- **If You Are Under Age 65 With End Stage Renal Disease (ESRD)**
  If You are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This includes the Medicare "three month waiting period" and the additional **30 months** after the Medicare effective date. After 33 months, the benefits described in this Benefit Description will be reduced by the amount that Medicare allows for the same *Covered Services*.
- **If You Are Under Age 65 With Other Disability**
  If You are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This is the case **only** if You are the actively employed Subscriber or the enrolled Spouse or child of the actively employed Subscriber.
- **If You Are Age 65 or Older**
  If You are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Description before Medicare. This can be the case **only** if You are an actively employed Subscriber or the enrolled Spouse of the actively employed Subscriber.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in Your Explanation of Benefits is the final determination and You will not receive notice of an adjusted cost share amount as a result of such recovery activity.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. The Claims Administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Claims Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator may not provide You with notice of overpayments made by the Plan or You if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Employer-Member-Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

The Employer is fiduciary agent of the Member. The Claims Administrator's notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not

responsible for payment of Covered Services of Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

Blue Cross and Blue Shield of Georgia Note

The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and Blue Cross and Blue Shield of Georgia (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Georgia. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business; to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications or Changes in Coverage

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

Policies and Procedures

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, in its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under Your Employer's Group Health Plan and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer’s Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. The Claims Administrator’s determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Care Received Outside the United States

You will receive Plan benefits for care and treatment received outside the United States. Plan provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time You receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with Your claim. All services will be subject to appropriateness of care. The Plan will reimburse You directly. Payment will be based on the Maximum Allowed Amount. Assignments of benefits to foreign providers or facilities cannot be honored.

You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to the Claims Administrator.

Governmental Health Care Programs

Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

WHEN COVERAGE TERMINATES

Termination of Coverage (Individual)

Membership for You and Your enrolled family members may be continued as long as You are employed by the Employer and meet eligibility requirements. It ceases if Your employment ends, if You no longer meet eligibility requirements, if the Plan ceases, or if You fail to make any required contribution toward the cost of Your coverage. In any case, Your coverage would end at the expiration of the period covered by Your last contribution.

Coverage of an enrolled child ceases at the end of the month, in which, the child attains the age limit shown in the Eligibility section. Coverage of a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Coverage of the Spouse of a Subscriber terminates at the end of the month as of the date of divorce or death.

Should You or any family Members be receiving covered care in the Hospital at the time Your membership terminates for reasons other than Your Employer's cancellation of this Plan, or failure to pay the required Premiums, benefits for Hospital Inpatient care will be provided until the date You are discharged from the Hospital.

Certification of Prior Creditable Coverage

If Your coverage under this Plan is terminated, You and Your Covered Dependents will receive a certification that shows Your period of coverage under this health benefit plan. You may need to furnish the certification if You become eligible under another group health plan. You may also need the certification to buy, for yourself or Your family, an individual policy that does not exclude coverage for medical conditions that were present before Your enrollment. You and Your Dependents may request a certification within 24 months of losing coverage under this health benefit plan.

You may also request a certification be provided to You at any other time, even if You have not lost coverage under this plan. If You have any questions, contact the customer service telephone number listed on Your Identification Card.

Continuation of Coverage (Federal Law-COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with federal law. If Your Employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when Your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your Spouse and Your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of Your family who is enrolled in the company's employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or

placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
For Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
For Spouses/ Dependents: A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Employee's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	36 months
For Dependents: Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if You become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for Your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

f You are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your Employer, and that bankruptcy results in the loss of coverage, You will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event
If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, Your Spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused Your Spouse or dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements
In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify

the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, You or an eligible family member must make an election within 60 days of the date Your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies You or Your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage You choose to continue. If the Premium rate changes for active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual
If You don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused You to be eligible initially for COBRA coverage under this Plan, You will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which You become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 72.5% of the cost for health coverage for You and Your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount You have to pay out of pocket.

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to You, You may continue COBRA coverage only until these limitations cease;
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the Group terminates all of its group welfare benefit plans.

Continuation of Coverage During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Continuation of Coverage Due to Family and Medical Leave (FMLA)

An Employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An Employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the Employee's child.
- The placement of a child with the Employee for the purpose of adoption or foster care.
- To care for a seriously ill spouse, child or parent.
- A serious health condition rendering the Employee unable to perform his or her job.

If the Employee chooses to continue coverage during the leave, the Employee will be given the same health care benefits that would have been provided if the Employee were working, with the same premium contribution ratio. If the Employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the Employee. It will tell the Employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of premium, the Employee's coverage will be restored to the same level of benefits as those the Employee would have had if the leave

had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. The Employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage. Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at *www.dol.gov/ebsa*.

DEFINITIONS

Accidental Injury
Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement
The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's group health plan.

Ambulance Services
A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Authorized Service(s)
A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the "Claims Payment" section.

Behavioral Health Care
Includes services for Mental Health Disorders and Substance Abuse.

Mental Health Disorders
Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Substance Abuse or Chemical Dependency
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. Substance Abuse services include:

Substance Abuse Rehabilitation Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individual treatment plans;

Substance Abuse Residential Treatment which is specialized 24 hour care that occurs in a licensed Residential Treatment Center (RTC) or intermediate care facility. It offers individualized and intensive treatment in a residential setting and includes:

- observation and assessment by a psychiatrist weekly or more frequently; and
- an individualized program of rehabilitation, therapy, education, and recreational or social activities in compliance with existing law.

Residential treatment provides an intermediate-term approach to treatment that attempts to return the patient to the community.

Substance Abuse Services within a General Hospital Facility (a general Hospital facility that provides services, on an Inpatient, 24-hour basis, for medical Detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or other drugs.

Benefit Period

One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Centers of Excellence (COE) Network

A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Blue Cross Blue Shield of Georgia was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

If a Member's coverage is limited to a certain percentage, for example 85%, then the remaining 15% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

Combined Limit

The maximum total of Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits**.

Complications of Pregnancy

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Cosmetic Surgery

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Creditable Coverage

Coverage under another health benefit plan is medical expense coverage with no greater than a 63 day gap in coverage under any of the following: (a) Medicare or Medicaid; (b) an employer-based accident and sickness insurance or health benefit arrangement; (c) an individual accident and sickness insurance policy; (d) a Spouse's benefits or coverage under Medicare or Medicaid or an employer-based health insurance benefit arrangement; (e) a conversion policy; or (f) similar coverage. The Claims Administrator will issue a certificate of Creditable Coverage upon request or when a Member leaves the Plan. Call the Customer Service number on Your Identification Card to request such a certificate.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical

person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible
The portion of the bill You must pay before Your medical expenses become Covered Services. It usually is applied on a calendar year basis.

Dependent
The Spouse/Domestic Partner and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children and stepchildren. Also included are Your children (or children of Your Spouse/Domestic Partner) for whom You have legal responsibility resulting from a valid court decree. Mentally retarded or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

Domestic Partner
Your same or opposite sex Domestic Partner who meets all the requirements on a Declaration of Domestic Partnership Form. You and Your Domestic Partner must submit an accurate and completed Declaration of Partnership Form, and meet all the requirements listed on this form. Continued eligibility of Your Domestic Partner depends upon the continuing accuracy of this form. Domestic Partner eligibility ends on the date a Domestic Partner no longer meets all the requirements listed on this form.

Detoxification
The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay
The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

Durable Medical Equipment
Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease of Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date
The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Emergency Medical Condition

("Emergency services," "emergency care," or "Medical Emergency") Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Employee

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

Experimental/Investigative

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;

- Has been determined by the FDA to be contraindicated for the specific use; or

- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a Service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Freestanding Ambulatory Facility

A facility, with a staff of Physicians, at which surgical procedures are performed on an Outpatient basis-no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Group Health Plan or Plan
An employee welfare benefit plan (as defined in Section 3(1) of ERISA, established by the Employer, in effect as of the Effective Date.

Health Plan Document
This Benefit Booklet in conjunction with the Health Plan Document, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Health Plan Document and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Health Plan Document, the Health Plan Document shall control.

Home Health Care
Care, by a licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency
A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate agency.

Hospice
A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate agency.

Hospice Care Program
A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital
An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

Identification Card
The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

Ineligible Charges

Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

Ineligible Provider
A provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a provider are not eligible for payment.

Infertile or Infertility
The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee
A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury
Bodily harm from a non-occupational accident.

Inpatient
A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit
A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Late Enrollees
Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan: (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

Maternity Care
Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

Maximum Allowed Amount
The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the "Claims Payment" section.

Medical Facility

A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit booklet. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Claims Administrator.

Medical Necessity or Medically Necessary

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Claims Administrator to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Member

Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

Network Provider

A physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements. **For Georgia and Missouri residents, only POS providers are Network Providers.**

New Hire

A person who is not employed by the Employer on the original Effective Date of the Plan.

Non-Covered Services

Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Out-of-Network Provider

A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical

practitioner or provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers. **For Georgia and Missouri residents, only POS providers are Network Providers.**

Out-of-Pocket Maximum
The maximum amount of a Member's Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

Pharmacy
An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

Physical Therapy
The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Plan
The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Administrator
The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor
The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Prior Authorization
The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order
A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each Plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a Group Health Plan Member or requires health benefit coverage of such child in such Plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a Group Health Plan.

Retail Health Clinic

A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.

Semiprivate Room

A Hospital room which contains two or more beds.

Skilled Convalescent Care

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility

An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by the Claims Administrator to meet the reasonable standards applied by any of the aforesaid authorities.

Spouse

For the purpose of this Plan, a Spouse is defined as a person who is married to a person of the opposite sex from that of the enrolling Employee.

Therapeutic Equivalent

Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

Transplant Providers

Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee of the Claims Administrator. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by a designee of the Claims Administrator.

Urgent Care

Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Utilization Review

A function performed by the Claims Administrator or by an organization or entity selected by the Claims Administrator to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, Outpatient care or diagnostic services are appropriate.

You and Your

Refer to the Subscriber, Member and each Covered Dependent.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's Network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, www.anthem.com.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group Health Plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., Your physician, nurse midwife, or physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Statement of Rights Under the Women's Cancer Rights Act of 1998

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. **See the Schedule of Benefits.**

If You would like more information on WHCRA benefits, call Your Plan Administrator.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If You or Your spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask Your Employer or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and Substance Abuse benefits with day/visit limits on medical/surgical benefits. In general, Group Health Plans offering mental health and Substance Abuse benefits cannot set day/visit limits on mental health or Substance Abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and Substance Abuse benefits offered under the plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out of pocket expenses on mental health and Substance Abuse benefits that is more restrictive than Deductibles, Copayment/Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If You are declining enrollment for yourself or Your Dependents (including Your spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, provided that You request enrollment within 31 days after Your other coverage ends.

In addition, if You have a new dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll yourself and Your dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Customer Service telephone number on Your ID Card, or contact Your Plan Administrator.

STATEMENT OF ERISA RIGHTS

NOTE: The Claims Administrator is not responsible for any statements contained herein that are not set forth in the Administrative Services Agreement or the Benefit Booklet.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each Member in an employee benefit Plan. This information is outlined below.

- **Plan Name: The YP Holdings LLC Welfare Benefit Plan**

- **Plan Sponsor: The YP Holdings LLC Welfare Benefit Plan**
  2247 Northlake Pwky., 8th Floor |
  Tucker, GA 30084

- **Plan Number: 501**

- **Employer I.D. Number: 80-0803728**

- **Type of Plan:** The Plan is an Employee welfare benefit plan providing group medical benefits.

- **Plan Year Ends:** 12/31

- **Type of Administration/Funding:** Medical benefits are furnished under a health care plan funded by the Plan Sponsor on a self-funded basis with claims being administered by Blue Cross and Blue Shield of Georgia on behalf of The YP Holdings LLC Welfare Benefit Plan

- **Plan Administrator and Named Fiduciary:** The YP Holdings LLC Welfare Benefit Plan

- **Agent for Service of Legal Process:** The YP Holdings LLC Welfare Benefit Plan

- **Description of Benefits.**
  The Plan Description sets forth the benefits provided under this Medical Plan. A brief explanation of these benefits may be found in the section entitled "**Schedule of Benefits**". A more detailed description of the benefits appears in the sections entitled "**Benefits**".

- **Eligibility for Participation**.
  The eligibility requirements for participation under this Medical Plan are set forth in the Plan Description in the section entitled "Eligibility".

- **Claims Procedures.**
  The Summary Plan Description contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Claims Administrator or the Plan Administrator. Note that the Claims Administrator is neither the Plan Administrator nor the administrator for the purposes of ERISA.

- **Review of Claim Denial.**
  If Your claim is denied in whole or in part, You will receive a notice of the denial. The notice will explain the reason for the denial.

  You, Your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request with the Claims Administrator for a review. In connection with such a request, documents pertinent to the administration of the Plan may be

reviewed and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.

Your request for review must be filed within 60 days after the receipt of the written notice of denial of a claim. A decision will be rendered no later than 30 days after the receipt of the request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision after the review shall be in writing and shall include specific reasons for the decision. This decision shall include specific reference to the pertinent benefit provisions of the Plan on which the decision is based. In any event, the Plan Administrator shall have the final authority regarding the disposition of disputed claims.

General Information About ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a Member of the Plan, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions;
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary financial report.

In addition to creating rights for You and other Employees, ERISA imposes duties on the people responsible for the operation of Your Employee benefit Plan. The people who operate Your Plan are called plan fiduciaries. They must handle Your Plan prudently and in the best interest of You and other Plan Members and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your right under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have Your claims reviewed and reconsidered.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan Administrator and do not receive them within 30 days, You may file suit in a federal court. In such case, the court may require the Plan Administrator to provide You the materials and pay You up to $110 a day until You receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. If plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order You to pay these expenses, for example, if it finds Your claim is frivolous. If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Claims Disclosure Notice

This Benefit Booklet contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or the Claims Administrator. In addition to this information, if this Plan is subject to ERISA, ERISA applies

some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to You, they will apply in place of any similar claim procedure rules included in this Benefit Booklet.

Urgent Care. The Plan must notify You, within 72 hours after receiving Your request for benefits, that the request has been received and what Your benefits are determined to be. If Your request for benefits does not contain all the necessary information, the Plan must notify You within 24 hours after receiving it and tell You what information is missing. Any notice to You by the Plan will be orally by telephone or in writing by facsimile or other fast means. You have at least 48 hours to give the Plan the additional information needed to process Your request for benefits. You may give the Plan the additional information needed orally by telephone or in writing by facsimile or other fast means.

If Your request for benefits is denied in whole or in part, You will receive a notice of the denial within 72 hours after the Plan's receipt of the request for benefits or 48 hours after receipt of all the information needed to process Your request for benefits, if the information is received in a timely manner as stated above. The notice will explain the reason for the denial and the Plan provision upon which the decision is based. You have 180 days to appeal the decision. You may appeal the decision orally by telephone or in writing by facsimile or other fast means. Within 72 hours after the Plan receives Your appeal, if Your claim is still considered urgent under the circumstances at the time of the appeal, the Plan must notify You of the decision. The Plan will notify You orally by telephone or in writing by facsimile or other fast means. If Your claim is no longer considered urgent, it will be handled in the same manner as a non-Urgent Care pre-service or post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The Plan must notify You, within 15 days after receiving Your request for benefits, that the request has been received and what Your benefits are determined to be. If the Plan needs more than 15 days to determine Your benefits, due to reasons beyond its control, the Plan must notify You within that 15-day period that more time is needed to determine Your benefits. But, in any case, even with an extension, the Plan cannot take more than 30 days to determine Your benefits. If You do not properly submit all the necessary information for Your claim, the Plan must notify You, within 5 days after receiving it and tell You what information is missing. You have 45 days to provide the Plan with the information needed to process Your request for benefits. The time period during which the Plan is waiting for receipt of the necessary information is not counted toward the time frame in which the Plan must make the benefit determination.

If Your claim is denied in whole or in part, You will receive a written notice of the denial within the time frame noted above after the Plan has all the information needed to process Your request for benefits, if the information is received in a timely manner as stated above. The written notice will explain the reason for the denial and the Plan provisions upon which the decision was made. You have 180 days to appeal an adverse benefit determination. Your appeal must be in writing. Within 30 days after a pre-service appeal is received, the Plan must notify You of the decision. The notice of the decision will be in writing.

Concurrent Care Decisions. If, after approving a request for benefits in connection with Your illness or Injury, the Plan decides to reduce or end the benefits that had been approved for You, in whole or in part:

- The Plan must notify You sufficiently in advance of the reduction in benefits, or the end of benefits, to allow You the opportunity to appeal the decision before the reduction in benefits or end of benefits occurs. In the notice to You, the Plan must explain the reason for reducing or ending Your benefits and the plan provisions upon which the decision was made.
- To keep the benefits You already have approved, You must successfully appeal the decision to reduce or end those benefits. You must make Your appeal to the Plan at least 24 hours prior to the occurrence of the reduction or ending of benefits. If You appeal the decision to

reduce or end Your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, Your appeal will be treated as if You were appealing a non-Urgent Care denial of benefits (see "Urgent Care" above).

- If Your appeal for benefits is received at least 24 hours prior to the occurrence of the reduction or ending of benefits, the Plan must notify You of the decision regarding Your appeal within 72 hours of the receipt of Your appeal. If Your appeal of the decision to reduce or end Your benefits is denied, in whole or in part, the Plan must explain the reason for the denial of benefits and the Plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an Urgent Care denial of benefits (see "Urgent Care" above).

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Plan must notify You, within 30 days after receiving Your request for benefits, that the request has been received and what Your benefits are determined to be. If more than 30 days are needed to determine Your benefits, due to reasons beyond the Plan's control, the Plan must notify You within that 30-day period that more time is needed to determine Your benefits. But, in any case, even with an extension, the Plan cannot take more than 45 days to determine Your benefits. If You do not submit all the necessary information for Your claim, the Plan must notify You, within 30 days after receiving it and tell You what information is missing. You have 45 days to provide the information needed to process Your claim. The time period during which the Plan is waiting for receipt of the necessary information is not counted toward the time frame in which the Plan must make the benefit determination.

If Your claim is denied in whole or in part, You will receive a written notice of the adverse benefit determination within the time frame stated above after the Plan has all the information needed to process Your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the Plan provisions upon which the decision was made. You have 180 days to appeal the adverse benefit determination. Your appeal must be in writing. Within 60 days after receiving Your appeal, the Plan must notify You of the decision. The notice to You of the decision will be in writing.

Note: You, Your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Plan and request a review of the adverse benefit determination. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed free of charge; and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

Medical information the Plan or the Claims Administrator has regarding Your case will be released to You or an attorney only by written authorization from Your provider and/or the Hospital.

- **Please Note: ERISA appeals will be administered by the Claims Administrator. Any appeals should be sent to Blue Cross and Blue Shield of Georgia.**

Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Anthem National Accounts business unit serves members of: Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California using the trade name Anthem Blue Cross in California; using the trade name of Anthem Blue Cross and Blue Shield for the following companies in: Colorado Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Connecticut: Anthem Health Plans, Inc.; Georgia: Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.; Indiana: Anthem Insurance Companies, Inc.; Kentucky: Anthem Health Plans of Kentucky, Inc.; Maine: Anthem Health Plans of Maine, Inc.; Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits; Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada.; New Hampshire: Anthem Health Plans of New Hampshire, Inc.; Ohio: Community Insurance Company; Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123.; Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. In 28 eastern and southeastern counties in New York, Empire Blue Cross Blue Shield, the trade name of Empire HealthChoice Assurance, Inc., underwrites and/or administers the PPO, EPO, POS and indemnity policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.