



HEALTH BENEFIT BOOKLET

BLUE ACCESS PPO

STATE OF INDIANA

Anthem Traditional Plan II ASO

Administered by Anthem Insurance Companies, Inc.

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INTRODUCTION

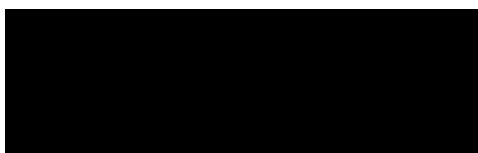
This Benefit Booklet has been prepared by the Administrator, on behalf of the Employer, to help explain your health benefits. This document replaces and supersedes any Benefit Booklet or summary that you have received previously. Please read this Benefit Booklet carefully, and refer to it whenever you require medical services.

This Benefit Booklet describes how to get medical care, what health services are covered and not covered, and what portion of the health care costs you will be required to pay. Many of the provisions in this Benefit Booklet are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. You are responsible for knowing the terms of this Benefit Booklet.

The coverage described in this Benefit Booklet is based upon the conditions of the Administrative Services Agreement issued to your Employer, and is based upon the benefit plan that your Employer chose for you. The Administrative Services Agreement, this Benefit Booklet and any endorsements, amendments or riders attached, form the Administrative Services Agreement under which Covered Services are available under your health care benefits.

Many words used in this Benefit Booklet have special meanings. These words are capitalized. If the word or phrase was not explained in the text where it appears, it may be defined in the "Definitions" section. Refer to these Definitions for the best understanding of what is being stated.

If you have any questions about this Benefit Booklet, please call the member service number located on the back of your Identification (ID) Card or visit www.anthem.com.



President

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You Have the Right to:

- Receive information about the organization and its services, practitioners and Providers, and Members' rights and responsibilities;
- Be treated respectfully, with consideration and dignity;
- Receive all the benefits to which you are entitled under the Plan;
- Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- Have a candid discussion with your Provider about treatment options, regardless of their cost or whether they are covered under the Plan;
- Participate with your Provider in decision making about your healthcare treatment;
- Refuse treatment and be informed by your Provider of the medical consequences;
- Receive wellness information to help you maintain a healthy lifestyle;
- Express concern and complaints about the care and services you received from a Provider, or the service you received from the Administrator, and to have the Administrator, on behalf of the Employer, investigate and take appropriate action;
- File a complaint with the Administrator, on behalf of the Employer, to Appeal that decision as outlined in the **Member Grievance** section of this Benefit Booklet, and to Appeal a decision to the Department of Insurance without fear of reprisal;
- Privacy and confidential handling of your information;
- Make recommendations regarding the Administrator's rights and responsibilities policies; and
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

As a Member, You Have the Responsibility to:

- Understand your health issues and be wise consumers of health care services;
- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship;
- Provide complete and honest information the Administrator needs to administer benefits and that Providers need to care for you;
- Follow the plan and instructions for care that you and your Provider have developed and agreed upon;
- Understand how to access care in routine, Emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Coinsurance, Copayments, etc.;
- Notify your Provider or the Administrator about concerns you have regarding the services or medical care you receive;

- Keep appointments for care and give reasonable notice of cancellations;
- Be considerate of other Members, Providers and the Administrator's staff;
- Read and understand your Benefit Booklet and Schedule of Benefits, and other materials from the Administrator or Employer concerning your health benefits;
- Provide accurate and complete information to the Administrator, on behalf of the Employer, about other health care coverage and/or insurance benefits you may carry; and
- Inform the Administrator and the Employer, of changes to your name, address, phone number, or if you want to add or remove Dependents.

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SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums and other limits that apply when you receive Covered Services from a Provider. Please refer to the "Covered Services" section of this Benefit Booklet for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Member’s responsibility for Covered Services.

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 a Non-Network Provider you are responsible for any balance due between the Non-Network Provider’s charge and the Maximum Allowable Amount in addition to any Coinsurance, Copayments, Deductibles, and **non Covered** charges.

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

BENEFIT PERIOD Calendar Year

DEPENDENT AGE LIMIT To the end of the calendar year in which the child attains age 19; or to the end of the calendar year in which the child attains age 23 if the child is a full-time student at an educational institution. For additional Dependent Information such as Disabled Dependent eligibility, see the Eligibility and Enrollment section of this Benefit Booklet.

DEDUCTIBLE	Network	Non-Network
Per Member (Single Coverage)	\$500	\$500
Per Family	\$500	\$500
	OR	
[<i>Tobacco Incentive-</i> Per Member (Single Coverage)	\$0	\$0
Per Family	\$0	\$0]

NOTE: The Deductible applies to all Covered Services with a Coinsurance amount. The Deductible, if applicable, must be satisfied before any Covered Services are paid by the Plan except for services with no Copayments/Coinsurance.

OUT-OF-POCKET LIMIT	Network	Non-Network
Per Member (Single Coverage)	\$2,000	\$2,000
Per Family	\$4,000	\$4,000

NOTE: The Out-of-Pocket Limit includes all Deductibles, Copayments and Coinsurance amounts you incur in a Benefit Period except for the following services:

- Prescription Drug benefits
- Non-Network Human Organ and Tissue Transplant services.

Once the Member and/or family Out-of- Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period except for the services listed above.

Network and Non-Network Copayments and Coinsurance are separate and do not accumulate toward each other. Network and Non-Network Out-of-Pocket Limits are NOT separate and DO accumulate toward each other.

LIFETIME MAXIMUMS	Network	Non-Network
Morbid Obesity Surgical Treatment Maximum	Unlimited (Network and Non-Network combined)	
TMJ Services Lifetime Maximum	\$2,500 (Network and Non-Network Combined) per Member	
Lifetime Maximum for all other Covered Services	\$2,000,000 (Network and Non-Network combined) per Member	

NOTE: While Prescription Drugs do not accumulate toward the Lifetime Maximum, once the Lifetime Maximum has been reached, no additional benefits for Prescription Drugs will be paid.

COVERED SERVICES**COPAYMENTS/COINSURANCE/MAXIMUMS****Network****Non-Network****Ambulance Services**

\$50 Copayment

\$50 Copayment

Behavioral Health Services

Coverage for the Inpatient and Outpatient treatment of Behavioral Health is provided to the same extent and degree as for the treatment of physical illness.

Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia)

Copayments/Coinsurance based on setting where Covered Services are received

40% Coinsurance

Diagnostic Services

When rendered as Physician Home Visits and Office Services or Outpatient Services the Copayment/Coinsurance is based on the setting where Covered Services are received except as listed below. Other Diagnostic Services and/or tests, including services received at an independent Network lab, may not require a Copayment/Coinsurance.

Laboratory services provided by a facility participating in the Administrator's Laboratory Network (as shown in the Provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient Hospital laboratory which is not part of the Administrator's Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.

NOTE: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received are subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Emergency Room Services
(Copayment/Coinsurance is waived if you are admitted)

\$75 Copayment per visit

\$75 Copayment per visit

Home Care Services

\$20 Copayment per day

40% Coinsurance

Maximum visits per Benefit Period

Unlimited
(Network and Non-Network combined)

NOTE: Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.

Private Duty Nursing \$5,000 per Member
 Lifetime Maximum

Hospice Services	20% Coinsurance	20% Coinsurance
Inpatient and Outpatient Professional Services	No Copayment/ Coinsurance up to the Maximum Allowable Amount	40% Coinsurance
Inpatient Facility Services	\$500 Copayment per admission	40% Coinsurance
Maximum days per Benefit Period for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	Unlimited (Network and Non-Network combined)	
Maternity Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Medical Supplies, Durable Medical Equipment and Appliances	20% Coinsurance	40% Coinsurance
(Includes certain diabetic and asthmatic supplies when obtained from a Non- Network Pharmacy.)		
Maximum per Benefit Period for Prosthetic devices received on an Outpatient basis (does not include surgical prosthetics or prosthetic limbs)	Unlimited (Network and Non-Network combined)	

Maximum per Benefit
 Period for all Durable
 Medical Equipment and
 Orthotics (does not include
 an Orthotic custom
 fabricated brace or support
 designed as a component
 for a Prosthetic limb)

Unlimited
 (Network and Non-Network combined)

Lifetime Maximum for
 Prosthetic limbs (includes
 an orthotic custom
 fabricated brace or support
 designed as a component
 for a Prosthetic limb)

Unlimited
 (Network and Non-Network combined)

NOTE: Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan. They are also subject to a separate lifetime maximum and do not apply to the Plan Lifetime Maximum.

NOTE: If Durable Medical Equipment or appliances are obtained through your PCP/SCP or another Network Physician's office, Urgent Care Center Services, Other Outpatient Services, Home Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where Covered Services are received.

Outpatient Services

Other Outpatient Services	No Copayment/Coinsurance up to the Maximum Allowable Amount	40% Coinsurance
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Note: Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Outpatient Surgery Hospital/Alternative Care Facility	\$250 Copayment per visit	40% Coinsurance
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**Physician Home Visits and
Office Services**

Primary Care Physician (PCP)	\$20 Copayment per visit	40% Coinsurance
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This Copayment/Coinsurance also applies to the following Covered Services regardless of Outpatient setting where they are received:

- Routine and Diagnostic Mammograms
- Diabetes self management training
- Medical nutritional therapy (Network only)

Specialty Care Physician (SCP)	\$20 Copayment per visit	40% Coinsurance
Allergy Injections	\$5 Copayment per visit	40% Coinsurance

NOTES: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received in a Physician's office are subject to the Other Outpatient Services Copayment/Coinsurance.

The allergy injection Copayment/Coinsurance will be applied when the injection(s) is billed by itself. The office visit Copayment/Coinsurance will apply if an office visit is billed with an allergy injection.

Preventive Care Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Surgical Services	No Copayments/Coinsurance up to the Maximum Allowable Amount	40% Coinsurance
Temporomandibular Joint (TMJ) Services (surgical and non-surgical)	Copayments/Coinsurance based on setting where Covered Services are received	40% Coinsurance
Therapy Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received

NOTE: If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation

Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.

Maximum Visits per Benefit Period for:

Physical Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Occupational Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Speech Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Manipulation Therapy	12 visits, combined Network and Non-Network.

Urgent Care Center Services	\$35 Copayment per visit	\$35 Copayment per visit. You are responsible for any amounts that exceed the Maximum Allowable Amount.
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Human Organ and Tissue Transplant Services

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to applicable Member cost shares.

Transplant Benefit Period

Network Transplant Provider

Non-Network Transplant Provider

Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34-50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility.

The later of 30 days or date of discharge following a Covered Transplant Procedure at a Non-Network Transplant Provider Facility.

Deductible

Network Transplant Provider

Non-Network Transplant Provider

Not Applicable

Applicable during the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.

Covered Transplant Procedure during the Transplant Benefit Period

Network Transplant Provider

Non-Network Transplant Provider

Copayment/Coinsurance based on place of setting, subject to the \$2,000 Out-of-Pocket Limit.

Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.

During the Transplant Benefit Period, You will pay 40% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit.

If the Provider is also a Network Provider for this Certificate (for services other than Transplant Services and Procedures), then you will **not** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount.

If the Provider is a Non-Network

Provider for this Certificate, you **will** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount.

Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.

Covered Transplant Procedure during the Transplant Benefit Period

Network Transplant Provider Professional and Ancillary (non-Hospital) Providers

Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers

Copayment/Coinsurance based on place of setting, subject to the \$2,000 Out-of-Pocket Limit.

Not Covered for Transplants received at a Non-Network Transplant Provider Facility

Transportation Lodging and Meals

Covered, as approved by the Plan, up to a \$10,000 benefit limit.

You are responsible for 40% of Maximum Allowable Amount after the Deductible has been met.

Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure

Covered, as approved by the Plan, up to a \$30,000 benefit limit.

Covered as approved by the Plan, up to a \$30,000 benefit limit. You will be responsible for 40% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.

Live Donor Health Services

Covered as determined by the Plan.

You will pay 40% of the Plan's Maximum Allowable Amount for Medically Necessary live organ donor expenses. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement.

Prescription Drugs

Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Retail Pharmacy (Network and Non-Network) 34 days or 100 units of medication (whichever is greater)

Mail Service 90 days

Retail Specialty Pharmacy (Network and Non-Network) and Specialty Mail Service 34 days or 100 units of medication (whichever is greater)

Network Retail Pharmacy Prescription Drug Copayment/Coinsurance

Tier 1 Prescription Drugs \$10 Copayment per Prescription Order

Tier 2 Prescription Drugs \$20 Copayment per Prescription Order

Tier 3 Prescription Drugs 40% Coinsurance (minimum \$40 & maximum \$100) per Prescription Order

Tier 4 Prescription Drugs 40% Coinsurance(minimum \$40 & maximum \$100) per Prescription Order

Anthem's Network Mail Service Program Prescription Drug Copayment/Coinsurance:

Tier 1 Prescription Drugs \$20 Copayment per Prescription Order

Tier 2 Prescription Drugs \$40 Copayment per Prescription Order

Tier 3 Prescription Drugs 40% Coinsurance(minimum \$80 & maximum \$150) per Prescription Order

Tier 4 Prescription Drugs 40% Coinsurance(minimum \$80 & maximum \$150) per Prescription Order

Specialty Network Retail Including Specialty Mail Service Program Prescription Drug Copayment/Coinsurance:

Tier 1 Specialty Prescription Drug \$10 Copayment per Prescription Order

Tier 2 Specialty Prescription Drug \$20 Copayment per Prescription Order

Tier 3 Specialty Prescription Drug 40% Coinsurance (minimum \$40 & maximum \$100) per Prescription Order

Tier 4 Specialty Prescription Drug 40% Coinsurance (minimum \$40 & maximum \$100)
per Prescription Order

Non-Network Retail Pharmacy and Non- 40% Coinsurance per Prescription Order
Network Specialty Pharmacy Prescription
Drug Copayment/Coinsurance:

NOTE: No Copayment/Coinsurance applies to certain Diabetic and asthmatic supplies, up to the Plan's Maximum Allowable Amount, when obtained from a Network Pharmacy. These supplies are covered as Medical Supplies, Durable Medical Equipment, and Appliances if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayments/Coinsurance.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **For most services, care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider to be a Covered Service, except for Emergency Care and Urgent Care. Services which are not received from a PCP, SCP or another Network Provider or approved as an Authorized Service will be considered a Non-Network service, except as specified above.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care and Urgent Care.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. The Administrator cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Plan, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization/Precertification has been obtained. The Administrator bases its' decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Administrator's clinical coverage guidelines and medical policy. The Administrator may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Benefit Booklet. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. The Plan's payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period Limit/Maximum, or Lifetime Maximum in this Benefit Booklet.**

Ambulance Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

Other vehicles which do not meet this definition, including but not limited to ambulances, are not Covered Services.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by The Plan to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

Behavioral Health Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include but are not limited to:

- **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.
- **Partial hospitalization** - an intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.
- **Intensive Outpatient treatment or day treatment** - a structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.
- **Outpatient treatment, or individual or group treatment** - office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family-therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

To assist you in obtaining appropriate and quality care, the Administrator will ask your Provider to submit a treatment plan after you have been evaluated after 10 Outpatient visits. The Administrator may discuss the goals of treatment and changes in the treatment plan, including alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

Non Covered Behavioral Health Services (please also see the Exclusions section of this Benefit Booklet for other non Covered Services)

- Custodial or Domiciliary Care.
- Supervised living or halfway houses.
- Services or care provided or billed by a residential treatment center, school, halfway house, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

- Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.

Coinsurance, Copayments and limits are specified in the Schedule of Benefits.

Dental Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are 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 patient'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 as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member who is physically or mentally disabled, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is

necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Diagnostic Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocardiograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic services other than those approved to be received in a Physician's office, you may be required to use the Administrator's independent laboratory Network Provider called the Reference Laboratory Network (RLN).

When Diagnostic services are performed within 3 days (72 hours) as part of pre-admission testing required for an Inpatient admission or an Outpatient surgery, no Copayment is required. Any Coinsurance will still apply.

When Diagnostic radiology is performed in a Network Physician's Office, no Copayment is required. Any Coinsurance from a Network or a Non-Network Physician will still apply.

Emergency Care and Urgent Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Medically Necessary services which the Administrator determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. In certain circumstances, Emergency Care received from a Non-Network Provider may be approved as an Authorized Service. You must contact the Administrator for authorization prior to the claim being filed. In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment/Coinsurance for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Administrator, on behalf of the Employer, or verify that your Physician has notified the Administrator of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Administrator, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with the Administrator or is a BlueCard Provider, you will be financially responsible for any care the Administrator, on behalf of the Employer, determines is not Medically Necessary.

The Behavioral Health Services Subcontractor also must be notified of all Emergency admissions for Behavioral Health services within 48 hours after admission or as soon as possible within a reasonable period of time.

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as a Non-Network service unless the Administrator authorizes the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Covered Services rendered by a Non-Network Urgent Care Center will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your Schedule of Benefits for benefit limitations.

Home Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.

- Nutritional Guidance.
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by the Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intramuscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months.

When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide.

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Inpatient Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Administrator, on behalf of the Employer. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.

- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

Maternity Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to the Administrator.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copayment.

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. the antepartum, intrapartum, and postpartum course of the mother and infant;
 2. the gestational stage, birth weight, and clinical condition of the infant;
 3. the demonstrated ability of the mother to care for the infant after discharge; and
 4. the availability of postdischarge follow-up to verify the condition of the infant after discharge.
- **Covered Services include at-home post delivery care visits** at your residence by a Physician or Nurse performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:
 1. parent education;
 2. assistance and training in breast or bottle feeding; and
 3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office.

In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

- Phenylketonuria.
- Hypothyroidism.
- Hemoglobinopathies, including sickle cell anemia.

- Galactosemia.
- Maple Syrup urine disease.
- Homocystinuria.
- Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health.
- Physiologic hearing screening examination for the detection of hearing impairments.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by the Administrator, on behalf of the Employer. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

The Administrator, on behalf of the Employer, may establish reasonable quantity limits for certain supplies, equipment or appliance described below. A detailed listing of supplies, equipment or appliances that are not covered by the Plan including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card or visit the Administrator's website at www.anthem.com. This list is subject to change.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** – Certain supplies and equipment for the management of disease that the Administrator approves are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Anthem's Prescription Drug benefit or if the supplies, equipment or appliances are not received from the Anthem Mail Service or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depo-Provera. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1. Allergy serum extracts
2. Chem strips, Glucometer, Lancets
3. Clinitest
4. Elastic stockings or supports. These items must be purchased by prescription or through a Hospital. They must be Medically Necessary for the treatment of an injury or condition requiring stockings. The Plan may establish reasonable limits on the number of pairs allowed per Member per Benefit Period.
5. Needles/syringes
6. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators
2. Arch supports
3. Doughnut cushions
4. Hot packs, ice bags
5. vitamins
6. medijectors

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Durable medical equipment** - The rental (or, at the Plan's option, the purchase) of durable Medical Equipment prescribed by a Physician or other Provider. Durable Medical Equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors
8. Augmentive communication devices are covered when the Administrator approves based on the Member's condition.

Non Covered items may include but are not limited to:

1. Air conditioners
2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

If you have any questions regarding whether specific durable medical equipment is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Non Covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.

5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

Non Covered Services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Prosthetic limbs & Orthotic custom fabricated brace or support** - Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:
 1. determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
 2. not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan. They are also subject to a separate lifetime maximum and do not apply to the Plan Lifetime Maximum.

Outpatient Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by the Administrator, on behalf of the Employer. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

For Emergency Accident or Medical Care refer to the Emergency Care and Urgent Care section.

Pervasive Developmental Disorder Services

Coverage is provided for the treatment of pervasive developmental disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Pervasive developmental disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any Exclusion or limitation in this Benefit Booklet in conflict with the coverage described in this provision will not apply. Coverage for pervasive developmental disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Plan.

Physician Home Visits and Office Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care", and "Home Care Services" for services covered by the Plan. For Emergency Care refer to the "Emergency Care and Urgent Care" section.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Preventive Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Preventive Care services include Inpatient services, Outpatient services and Physician Home Visits and Office Services. These services may vary based on the age, sex, and personal history

of the individual, and as determined appropriate by the Administrator's clinical coverage guidelines. 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.

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. (Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.) Examinations include, but are not limited to:
 1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
 2. Adult routine physical examinations.
 3. Pelvic examinations.
 4. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
 5. Annual dilated eye examination for diabetic retinopathy.

- Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follows the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians.

These include, but are not limited to:

1. Hepatitis A vaccine.
2. Hepatitis B vaccine.
3. Hemophilus influenza b vaccine (Hib).
4. Influenza virus vaccine.
5. Rabies vaccine.
6. Diphtheria, Tetanus, Pertussis vaccine.
7. Mumps virus vaccine.
8. Measles virus vaccine.
9. Rubella virus vaccine.

10. Poliovirus vaccine.

- Screening examinations:
 1. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts.
 2. Routine hearing screening.
 3. Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
 4. Routine cytologic and chlamydia screening (including pap test).
 5. Routine bone density testing for women.
 6. Routine prostate specific antigen testing.
 7. Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Diabetes Self Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Medical Nutritional Therapy limited to consultations for the Medically Necessary management and treatment of obesity. Any Prescription Drug or medical supply prescribed as a part of this therapy will not be covered except as otherwise stated under this Benefit Booklet.

Surgical Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;

- Usual and related pre-operative and post-operative care;
- Other procedures as approved by the Administrator, on behalf of the Employer.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact the Administrator, on behalf of the Employer, for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Surgical Services for Morbid Obesity, described in more detail below, shall be covered the same as any other Medically Necessary Surgical Service subject to any maximums in the Schedule of Benefits.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy. See “Mastectomy Notice” below for further coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactyly;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Morbid Obesity Treatment Services

Covered Services include surgical treatment of morbid obesity:

- that has persisted for at least five (5) years; and
- for which nonsurgical treatment supervised by a Physician has been unsuccessful for at least six (6) consecutive months.

The Plan will not cover services for the surgical treatment of morbid obesity for a Member younger than 21 years of age unless two (2) Physicians licensed under Indiana Code 25-22.5 (one who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in Indiana) determine that the surgery is necessary to:

- save the life of the Member; or
- restore the Member's ability to maintain a major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency);

and each Physician documents in the Member's medical record the reason for the Physician's determination.

“Morbid obesity” means:

- a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

Surgical Treatment for Morbid Obesity may be limited. See the Schedule of Benefits.

Sterilization

Sterilization is a Covered Service.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

Therapy Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, or vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft

tissue mobilization, myofascial; adaptations to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage the Plan will not require you to receive dialysis treatment at a Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non Covered Services for physical medicine and rehabilitation include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Human Organ and Tissue Transplant Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ and tissue transplants or transfusions as determined by the Administrator, on behalf of the Employer, including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 -50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility or the later of 30 days or date of discharge following a Covered Transplant Procedure at a Non-Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize your benefits, the Administrator strongly encourages you to call its transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. The Administrator will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or Exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card **and ask for the transplant coordinator**. Even if the Administrator issues a prior approval for the Covered Transplant Procedure, you or your Provider must call the Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation, Meals and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator, on behalf of the Employer, 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, lodging and meals for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. The Member must

submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator for detailed information.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Prescription Drug Benefits

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pharmacy Benefits Manager

The pharmacy benefits available to you under the Plan are managed by the Administrator's Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which the Administrator contracts to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, a Specialty Pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating, the covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and operating a Mail Service pharmacy, and a Specialty Drug Pharmacy Network. The PBM, in consultation with the Administrator, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Administrator at the Customer Service telephone number on the back of your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Plan can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The Administrator, or the PBM, use pre-approved criteria, developed by the Administrator's Pharmacy and Therapeutics Committee which is reviewed and adopted by the Administrator. The Administrator or the PBM may contact your Provider if additional

information is required to determine whether Prior Authorization should be granted. The Administrator communicates the results of the decision to both you and your Provider.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the Member Grievances section of this Benefit Booklet.

For a list of the current Drugs requiring Prior Authorization, please contact the Administrator at the Customer Service telephone number on the back of your ID card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage under your Plan. Refer to the Prescription Drug benefit sections in this Benefit Booklet for information on coverage, limitations and Exclusions. Your Provider or Network Pharmacist may check with the Administrator to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Plan.

Therapeutic Substitution of Drugs is a program approved by the Administrator and managed by the PBM. This is a voluntary program designed to inform Members and Physicians about possible alternatives to certain prescribed Drugs. The Administrator, or the PBM, may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic Drug substitutes, contact the Administrator by calling the Customer Service telephone number on the back of your ID card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

Step Therapy

Step therapy protocol means that a Member may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Specialty Pharmacy Network

The Administrator's Specialty Pharmacy Network is available to members who use Specialty Drugs.

"Specialty Drugs" are Prescription Legend Drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Network Specialty Pharmacies may fill both retail and mail service Specialty Drug Prescription Orders, subject to a 30 day supply for Retail and Mail Service, and subject to the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

Network Specialty Pharmacies have dedicated patient care coordinators to help you manage your condition and offer toll-free twenty-four hour access to nurses and registered Pharmacists to answer questions regarding your medications.

You may obtain a list of the Network Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your ID card, or review the lists on the Administrator's website at www.anthem.com.

Covered Prescription Drug Benefits

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs are covered when obtained through an eligible Pharmacy.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact the Administrator to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Injectables.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.
- Smoking Cessation Prescription Drugs (no over the counter drugs).
- Contraceptive devices, oral immunizations, and biologicals. If such items are cover the counter Drugs, devices or products, they are not Covered Services.
- Treatment of Onchomycosis (toenail fungus).

Non Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other non Covered Services)

- Over the counter drugs
- Over the counter vitamins
- Prescription vitamins (covered if treating a medical condition)
- Retin-A (covered if treating a medical condition)
- Diet Pills (Anorexiant)
- Fluoride Supplements

- Experimental/ Investigative Drugs
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your scheduled Copayment/Coinsurance amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance/Copayment. If you receive Covered Services from a Non-Network Pharmacy, a Deductible and Coinsurance/Copayment amount may also apply.

Days Supply

The number of days supply of a Drug which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days supply allowed for under this Plan, you should ask your Pharmacist to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

Tiers

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by the Plan as a first, or second, or third, or fourth “tier” Drug. The determination of tiers is made by the Administrator, on behalf of the Employer, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

- Tier 1 generally includes Generic Prescription Drugs.
- Tier 2 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other Drugs.
- Tier 3 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other Drugs in lower tiers.
- Tier 4 generally includes injectable Drugs. The list of Tier 4 Drugs can be found at www.Anthem.com or by calling the number on the back of your Identification Card.

Special Programs

From time to time the Administrator may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic

Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

Half-Tablet Program

The Half-Tablet Program will allow Members to pay a reduced Copayment on selected “once daily dosage” medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take “½ tablet daily” of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member’s decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the Administrator at the number on the back of your Identification Card.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, including a Network Specialty Pharmacy, a Non-Network Pharmacy, or the Anthem Mail Service Program. It is also based upon which Tier the Administrator has classified the Prescription Drug or Specialty Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The Administrator, on behalf of the Employer, retains the right at its discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copayment/Coinsurance for which you are responsible.

Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network or Specialty Drug Network Pharmacy or through the Anthem Mail Service, you are responsible for all Deductibles and/or Copayment/Coinsurance amounts.

For Covered Services provided by a Non-Network Pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

Network Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to the Administrator with a written request for refund.

Specialty Drugs - You or your Physician can order your Specialty Drugs directly from PrecisionRx Specialty Solutions OR a Specialty Network Pharmacy, simply call 1-800-870-6419. If you or your Physician orders your Specialty Drugs from Precision Rx Specialty Solutions you will be assigned a patient care coordinator who will work with you and your Physician to obtain Prior Authorization and to coordinate the shipping of your Specialty Drugs directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your Specialty Drug Prescription.

Non-Network Pharmacy – You are responsible for payment of the entire amount charged by the Non-Network Pharmacy. You must submit a Prescription Drug claim form to the Plan for reimbursement consideration. These forms are available from the Administrator and/or the Employer. You must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to the Plan. The itemized receipt must show:

- name and address of the Non-Network Pharmacy;
- patient's name;
- prescription number;
- date the prescription was filled;
- name of the Drug;
- cost of the prescription;
- quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by Anthem or the PBM's normal or average contracted rate with network pharmacies on or near the date of service.

Anthem Mail Service – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill.

NON COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded and are not considered Covered Services. Unless otherwise stated in this Plan's Benefits' Article, no benefits are provide for care and supplies related to:

- Human organ or tissue transplants other than as specifically stated as covered in the Benefits' Article.
- Artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
- Artificial insemination.
- In vitro fertilization.
- Gamete intra fallopian transfer (GIFT).
- Immunizations except as specifically stated.
- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- Reversal of sterilization.
- Services or supplies prescribed, ordered or referred by or received from a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.
- Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
- Hearing aids or examinations for prescribing or fitting them.
- Services, supplies, or charges which the Plan determines are not Medically Necessary or do not meet the Plan's medical policy, clinical coverage guidelines, or benefit policy guidelines.
- Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional. This includes services at residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- Dental treatment, regardless of origin or cause, except as specified elsewhere in this Plan's Benefits' Article. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service as stated in this Plan's Benefits' Article) or gums, including but not limited to: extraction, restoration and replacement of teeth;
 - Medical or surgical treatments of dental conditions; and
 - Services to improve dental clinical outcomes.

- Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- Dental implants.
- Dental braces.
- Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
 1. Transplant preparation;
 2. Initiation of immunosuppressives; or
 3. Direct treatment of acute traumatic injury, cancer or cleft palate.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Health Care benefit as specifically stated in this Plan's Benefits' Article.
- Routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
 1. cleaning and soaking the feet;
 2. applying skin creams in order to maintain skin tone; or
 3. other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- Any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
- Examinations relating to research screenings.
- Developmental delays except for Pervasive Developmental Disorders (including Asperger's syndrome and autism) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, learning disabilities, hyperkinetic syndromes, or mental retardation (except for Prescription Drugs).
- Illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
- Services and supplies for which you have no legal obligation to pay in the absence of this or like coverage.
- Services and supplies incurred prior to your Effective Date.
- Services and supplies incurred after the termination date of this coverage except as specified elsewhere.
- Services or supplies provided by a sanitarium, or rest cures.

- Services or supplies furnished by any person or institution acting beyond the scope of her/his/its license.
- Plan benefits to the extent that the services are a Medicare Part A or Part B liability.
- Services and supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Services and supplies to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- Mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by the Plan or specifically stated as a Covered Service. Services or supplies if the Plan does not state that benefits are provided for them.
- Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Plan.
- Missed or canceled appointments.
- Completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Recreation or diversionary therapy.
- The cost of materials used in any Occupational Therapy.
- Personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.
- Hospitalization for environmental change or Provider charges connected with prescribing an environmental change.
- Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in this Plan's Benefits' Article. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity as required by law are covered. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
- The treatment of abuse of nicotine from tobacco or other sources, except for nicotine substitutes, which require a prescription under federal law.
- Stand-by charges of a Physician.
- Sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
- Drugs in quantities which exceed the limits established by the Plan.

- The Prescription Drug Copayment/Coinsurance portion of the Pharmacy Benefits Manager.
- 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 provide their test results.
- Diagnostic testing or treatment related to infertility.
- Marital counseling.
- Services and supplies received from an individual or entity that is not a Provider, as defined in this Plan's Benefits' Article, or recognized by the Plan.
- A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- Expenses incurred at a health spa or similar facility..
- Self-help training and other forms of non-medical self care, except as otherwise provided herein.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, or for licensing.
- Services and supplies for Skilled Nursing Facilities.
- **EXPERIMENTAL/INVESTIGATIVE SERVICES**
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 Plan determines to be Experimental/Investigative is not covered under the Plan.

The Plan will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if it 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 Plan. In determining whether a Service is Experimental/Investigative, the Plan 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 Plan 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 Plan 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.

- Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- Court ordered testing or care unless Medically Necessary.
- Charges in excess of the Maximum Allowable Amount.
- Procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law. Complications directly related to cosmetic services treatment or surgery are not covered.
- Vision orthoptic training.
- Care received in an emergency room which is not Emergency Care, except as specified as covered.
- Chiropractic services rendered in the home as part of Home Care Services.
- Alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST) and iridology-study of the iris.
- Hiring, or the services of, a surrogate mother.
- Surgical treatment of gynecomastia.
- Treatment of hyperhidrosis (excessive sweating).
- Any service for which a Covered Person is responsible under the terms of this Plan to pay a Coinsurance or Deductible, and the Coinsurance or Deductible is waived by a non-Network Provider.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Elective abortions.

ELIGIBILITY AND ENROLLMENT

You have coverage provided under the Plan because of your employment with/membership with/retirement from the Employer. You must satisfy certain requirements to participate in the Employer's benefit plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by the Employer or state and/or federal law and approved by the Administrator, on behalf of the Employer.

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

Eligibility

- (1) All active full-time (37.5 hours per week) employees and their eligible "dependents".
- (2) All appointed or elected officials and their eligible "dependents".
- (3) Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.
- (4) "Dependent" means:
 - a) Spouse of an employee;
 - b) Any unmarried dependent children, step-children, foster children, legally adopted children of the employee or Spouse, or children who reside in the employee's home for whom the employee or Spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "Dependent" until marriage or the end of the Calendar Year in which he/she attains age 19/23.

In the event a child who is a "Dependent" as defined herein, is both:

1. incapable of self-sustaining employment by reason of mental or physical disability,
and
 2. is chiefly dependent upon the employee for support and maintenance;
prior to age 19, such child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "Dependent" will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The Plan requires annual documentation from a physician after the child's attainment of the limiting age.
- (5) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Legislator" who meets the following:
 - a) Is no longer a member of the General Assembly;
 - b) Who served as a legislator for at least 10 years.A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's Spouse covered under the health insurance program. In

addition, the surviving Spouse of a legislator who has died may elect to participate in the group health insurance program if all of the following apply:

1. The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the date of the legislator's death;
 2. The surviving Spouse files a written request for insurance coverage with the employer;
 3. The surviving Spouse pays an amount equal to the employer's and employee's Premium for the group health coverage for an active employee.
- The eligibility of the retired legislator's Spouse, or a surviving Spouse of a legislator for group health coverage is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. The Spouse's eligibility ends on the earliest of the following:
1. When the employer terminates the health coverage program;
 2. The date of the Spouse's remarriage;

"Dependent" for a "Retired Legislator" means a person who:

- a. Is a dependent child, stepchild, foster child, or adopted child of a former legislator or Spouse of a former legislator or a child who resides in the home of a former legislator or Spouse of a former legislator who has been appointed legal guardian for the child; and
- b. Is less than twenty-four (24) years of age; at least twenty- four (24) years of age, incapable of self-sustaining employment by reason of mental or physical disability, and is chiefly dependent on a former legislator or Spouse of a former legislator for support and maintenance; or at least twenty- four (24) years of age.

(6) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

- a) Must retire before January 1, 2007
- b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
- c) Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;
- d) Must have fifteen (15) years of participation in a retirement fund.

(7) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

- i. Must retire after December 31, 2006.
- ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
- iii. Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement.

(8) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

- i. Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;
- ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

- iii. Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement;
- (9) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:
 - a) Retirement date is after June 30, 1990;
 - b) Will have reached the age of sixty-two (62) on or before retirement date;
 - c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;
 - d) Who has at least eight (8) years of service credit as a participant in the Judge's retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge's retirement.
 - (10) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:
 - a) Who is a retired participant under the Prosecuting Attorney's Retirement fund;
 - b) Whose retirement date is after January 1, 1990;
 - c) Who is at least sixty-two (62) years of age;
 - d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
 - e) Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.
 - (11) Retirees eligible under subsections 6 - 10 must file a written request for the coverage within ninety (90) days after retirement. The Spouse's subsequent eligibility to continue insurance under the surviving Spouse's eligibility end on the earliest of the following:
 - a) Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the Spouse would be eligible to remain covered until the end of the maximum period under COBRA;
 - b) When the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
 - c) The end of the month following remarriage; or
 - d) As otherwise provided in I.C. 5-10-8-8(g).
 - (12) Employee on a leave of absence for ninety (90) days or less and out of pay status
 - (13) An employee on family leave
 - (14) Retirees eligible under IC 5-10-12.
 - (15) A former legislator, dependent, or Spouse as defined and pursuant to the conditions set forth in IC 5-10-8-8.2.
 - (16) All active and retired full-time and part-time employees, elected or appointed officers and officials of a local unit of government that elect to provide health coverage under this plan. A local unit of government is defined as follows:
 - a) A city, town, county, township, public library, or school corporation
 - b) Any board, commission, department, division, authority, institution, establishment, facility, or governmental unit under the supervision of either the state or a city, town, county, township, public library, or school corporation, having a payroll in relation to persons it immediately employs, even if it is not a separate taxing unit.
 - (17) As otherwise provided by Act of the Indiana General Assembly.

Effective Date of Your Coverage

“For specific information concerning your Effective Date of coverage under this Plan, you should see your Human Resources or benefits department.”

Coverage for a newborn child is effective from the moment of birth. Covered Services include the treatment of any injury or illness such as congenital deformity, hereditary complication, premature birth, and routine nursery care. Newborn must be formally added to the Employee’s policy through ‘family status’ change process. See NEWBORN INFANT COVERAGE.

Newborn Infant Coverage

The benefits payable for covered Dependent children shall be paid for a sick or injured newborn infant of a Covered Person for the first 30 days of his or her life. The coverage for newly adopted children will be the same as for other covered Dependents. The coverage for the newborn infant or newly adopted child consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for the newborn infant or newly adopted child shall include, but not be limited to, benefits for Inpatient or Outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:
 - a) The date of placement for the purpose of adoption; or
 - b) The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;
2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or
3. Continues unless required action as described below is not taken.

To be covered beyond the first 30 days, the newborn or newly adopted child must be added to the Covered Person's Plan enrollment within the first 30 days after birth or adoption.

If the Enrollee must change to coverage with a higher fee to add the child, the Enrollee will be liable for the higher fee for the entire period of the child’s coverage, including the first 30 days.

Federal Laws Related to Your Coverage

In the past few years, Congress has passed several laws that have affected our group health plans. These laws are designed to reduce Medicare expenditures by requiring that active employees and/or their Dependents who are either age 65 or over, or disabled to elect either:

- a) our group health plan, or
- b) Medicare as their primary coverage.

The preference is option (a) since option (b) would require the discontinuance of the group medical plan. In addition, Medicare no longer requires enrollment in the Part B Supplemental Medical Insurance Benefit for which there is a charge so long as you remain covered under our group medical plan.

CHANGES IN COVERAGE: TERMINATION, CONTINUATION & CONVERSION

Termination

Individual Termination

Your coverage will terminate on the earliest of the following dates:

- On the date the group Plan is terminated.
- On the last day of the period for which Premiums have been paid, if the State of Indiana fails to pay the required Premiums for you, except when resulting from clerical mistake or inadvertent error.
- On the last day of the period for which Premiums have been paid in which you leave or are dismissed from employment.
- On the date your Dependent(s) cease(s) to be a covered Dependent.
- Upon the date of your death, coverage for your Dependents shall terminate at the end of the period for which Premiums have been paid.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for 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. Certifications may be requested within 24 months of losing coverage. If you have any questions, contact the customer service telephone number listed on the back of your Identification Card.

Continuation

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Employer which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Employer's health plan. It can also become available to other Members of your family, who are covered under the Employer's health plan, when they would otherwise lose their health coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Employer's health plan, you should contact the Employer.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Employer's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. 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 coverage under the Employer's health plan is lost because of the qualifying event. Under the Employer's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Employer for Fee payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Employer's health plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Employer's health plan as a "Dependent child."

If Your Employer Offers Retirement Coverage

Sometimes, 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 the Employer, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Employer's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also

become qualified beneficiaries if bankruptcy results in the loss of their coverage under Employer's health plan.

When is COBRA Coverage Available

The Employer will offer COBRA continuation coverage to qualified beneficiaries only after the Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then the Employer will notify the COBRA Administrator (e.g., Human Resources, external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued only for up to a total of 18 months. In the case of losses of coverage due to the Subscriber's death, divorce or legal separation, the Subscriber's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the Employer's health plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement.

How Can You Extend The Length of COBRA Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Employer of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

- **Disability**

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. You must provide the SSA determination of your disability to the Employer within 60 days of receipt. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Employer of that fact within 30 days after SSA's determination.

- **Second Qualifying Event**

An 18-month extension of coverage will be available to spouses and Dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Subscriber, divorce or separation from the covered Subscriber, the covered Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Employer's health plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Employer within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Trade Act of 1974

Special COBRA rights apply to Subscribers who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Employer health plan coverage ended.

If you, the Subscriber, qualify for assistance under the Trade Act of 1974, you should contact the Employer for additional information. You must contact the Employer promptly after qualifying for assistance under the Trade Act of 1974 or you will lose these special COBRA rights.

Premiums and the End of COBRA Coverage

Premium will be no more than 102% of the Employer rate (unless your coverage continues beyond 18 months because of a disability. In that case, Premium in the 19th through 29th months may be 150% of the Employer rate).

Continuation coverage will be terminated before the end of the maximum period if:

- any required Premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another Employer health plan that does not impose any pre-existing condition Exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Employer would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

Questions concerning your Employer's health plan and your COBRA continuation coverage rights should be addressed to the 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 nearest Regional or District Office of 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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying your Employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If Your military service is for a period of time less than 31 days, You may not be required to pay more than the active Member contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under the Plan shall be the lesser of:

1. The 24-month period beginning on the first date of your absence from work; or
2. The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under the Plan. No Exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Employer must provide the Administrator with evidence satisfactory to the Employer of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Service from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care, Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider, or the Administrator to be sure that Prior Authorization and/or precertification has been obtained.

If a Non-Network Provider meets the Plan's enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network Provider for the product associated with the Plan.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider benefits will be paid at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of Physicians. The Administrator, on behalf of the Employer, has final authority to determine the Medical Necessity of the service.

The Administrator, on behalf of the Employer, may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. Any further changes will be your responsibility. You may appeal this decision. See the **Member Grievances** section of this Benefit Booklet.

- **Network Providers** - include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with the Administrator to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatrician or other Network Providers as allowed by the Plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange your health care services. SCP's are Network Physician who provide specialty medical services not normally provided by a PCP.

For services rendered by Network Providers:

1. You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from the Plan and not from you except for approved Coinsurance, Copayments and/or Deductibles. You may be billed by your Network Provider(s) for any **non Covered Services** you receive or when you have not acted in accordance with the Plan.

2. Health Care Management is the responsibility of the Network Provider.

If there is no Network Provider who is qualified to perform the treatment you require, contact the Administrator prior to receiving the service or treatment and the Administrator, on behalf of the Employer, may approve a Non-Network Provider for that service as an Authorized Service.

Non-Network Services

Services which are not obtained from a PCP, SCP, or another Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exception is Emergency Care and Urgent Care. In addition, certain services are not covered unless obtained from a Network Provider, see your Schedule of Benefits.

For services rendered by a Non-Network Provider, you are responsible for:

- The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Coinsurance/Copayments;
- Services that are not Medically Necessary;
- Non Covered Services;
- Filing claims; and
- Higher cost sharing amounts.

Relationship of Parties (Plan - Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under the Plan has the right to services or benefits under the Plan. If anyone receives services or benefits to which they are not entitled to under the terms of this Benefit Booklet, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

When you receive care through a Network Provider, you are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

A claim must be filed for you to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit your claim for you. If you submit the claim, use a claim form.

How Benefits Are Paid

Maximum Allowable Amount

The amount that the Administrator, on behalf of the Employer, or the Administrator's Subcontractor, determines is the maximum payable for Covered Services you receive. To determine the Maximum Allowable Amount for a Covered Service, the Administrator or the Administrator's Subcontractor use, in addition to other information, internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement for this product, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with the Administrator for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

For a Non-Network Provider which is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services under this product or any other product. In the absence of a negotiated amount, the Administrator, on behalf of the Employer, shall have discretionary authority to establish as the Administrator deems appropriate, the Maximum Allowable Amount. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility's charge, or an amount determined by the Administrator, after consideration of any one or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that the Administrator may have made, or other factors the Administrator, on behalf of the Employer, deems appropriate.

It is your obligation to pay any Coinsurance, Copayments and Deductibles, and any amounts which exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its participation agreement with the Administrator, on behalf of the Employer.

Member Share of Cost

What you pay often depends on the type of service you receive and if you use a Network or Non-Network Provider. Refer to the "Schedule of Benefits" section of this Benefit Booklet to see what amount you are required to pay for each Covered Service.

This Plan shares the cost of your medical expenses with you up to a pre-determined amount, or the Maximum Allowable Amount. The Plan will not pay any portion of any charge that exceeds this amount.

Services may be subject to a Coinsurance, Copayment and/or Deductible, as outlined in the Schedule of Benefits. Deductibles will be based on the Maximum Allowable Amount. Coinsurance and Copayments are your share of the cost for Covered Services, and must be paid at the time you receive the Covered Services. The Plan pays the share of the balance up to the Maximum Allowed Amount.

Network Providers will seek payment from the Plan for Covered Services for the Maximum Allowable Amount, and will accept this amount as full payment.

If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the actual amount billed and the Maximum Allowable Amount, plus any Deductible, Coinsurance, Copayments and charges for **non Covered** Services.

However, these guidelines change when you receive Covered Services in a Network Provider facility, but from a Non-Network Provider. If you receive Covered Services in a Network Provider facility from a Non Network Provider such as an anesthesiologist who is employed by or contracted with that Network Facility, benefits will be paid. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full under a Network Provider's participation agreement for this product. You may be liable for the difference between the billed charge and the Plan's Maximum Allowable Amount. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The Plan will not pay any portion of any charge that exceeds the Maximum Allowable Amount.

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 Allowable Amount. **If services are performed by Non Network Providers**, then you are responsible for

any amounts charged in excess of the Plan's Maximum Allowable Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact the Administrator for more information.

Payment of Benefits

You authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan'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 state law.

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

Notice of Claim

The Plan is not liable, unless the Administrator receives written notice that Covered Services have been given to you. The notice must be given to the Administrator, on behalf of the Employer, within 90 days of receiving the Covered Services, and must have the data the Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Administrator needs to process the claim, then the necessary data must be submitted to the Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If the Administrator has not received the information it needs to process a claim, the Administrator will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, the Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator, on behalf of the Employer, will make its request for additional information within 30 days of the Administrator's initial receipt of the claim and will complete the Administrator's processing of the claim within 15 days after the Administrator's receipt of all requested information. An expense is considered incurred on the date the service or supply was given. **If the Administrator is unable to complete processing of a claim because you or your Provider fail to provide the Administrator with the additional information within 60 days of its request, the claim will be denied and you will be financially responsible for the claim.**

Failure to give the Administrator notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Time Benefits Payable

The Plan will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If the Administrator has not received the information it needs to process a claim, the Administrator will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, the Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator will make its request for additional information within 30 days of the Administrator's initial receipt of the claim and will complete the Administrator's processing of the claim within 15 days after the Administrator's receipt of all requested information.

At the Plan's discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, the Plan may reimburse those other parties and be fully discharged from that portion of its liability.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to the Administrator, or contact Customer Service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the claim forms, written notice of services rendered may be submitted to the Administrator without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits (EOB)

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 from the Plan 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).
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

BlueCard Program

When you obtain health care services through the BlueCard Program outside the geographic area the Administrator serves, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto the Administrator, on behalf of the Employer.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Administrator, on behalf of the Employer, would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area the Administrator serves if the Plan covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area the Administrator serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area the Administrator serves. But in no event will you be

entitled to benefits for health care services, wherever you received them, that are specifically excluded or limited from coverage by the Plan.

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 Identification Card or go to www.anthem.com for more information about such arrangements.

HEALTH CARE MANAGEMENT

Health Care Management includes the processes of Precertification, Predetermination and Medical Review. Its purpose is to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources and optimizing the health of the Members. These processes are described in the following section.

If you have any questions regarding the information contained in this section, you may call the Precertification telephone number on the back of 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 Administrator within 48 hours of 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 Administrator will review your Benefit Booklet 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 Benefit Booklet or is Experimental/Investigative as that term is defined in this Benefit Booklet.

Medical 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 Administrator has a related clinical coverage guideline and are typically initiated by the Administrator.

Most Network Providers know which services require Precertification and will obtain any required Precertification or request a Predetermination if they feel it is necessary. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. The ordering Provider, facility or attending Physician will contact the Administrator to request a Precertification or Predetermination review (“requesting Provider”). The 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	Services provided by a BlueCard/Non-Network/Non-Participating Provider
Provider	<ul style="list-style-type: none"> • Member is responsible for Precertification. • Member is financially responsible for service and/or setting that are/is not covered under the Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative.

The Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventative care clinical coverage guidelines, to assist in making Medical Necessity decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. The Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Benefit Booklet and the Administrative Services Agreement take 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 Precertification telephone number on the back of your Identification 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. Medical Reviews are 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 on state and federal regulations. Where state regulations are stricter than federal regulations, the Administrator will abide by state regulations.

You may call the telephone number on the back of your membership card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
<i>Precertification Requests</i>	
Prospective Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	2 business days from the receipt of the request
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 or 2 business days from the receipt of request whichever is less
Concurrent Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
<i>Predetermination Requests</i>	
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
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

If additional information is needed to make the Administrator’s decision, the 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 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 Administrator’s possession.

The Administrator will provide notification of its decision in accordance with state and 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. Premiums must be paid for the time period that services are rendered;
3. the service or surgery must be a covered benefit under the Plan;
4. the service cannot be subject to an Exclusion under the plan, including but not limited to a Pre-Existing Condition limitation or Exclusion; and
5. you must not have exceeded any applicable limits under the Plan.

CARE MANAGEMENT

Care Management is a Health Care Management feature 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 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.

The Administrator's 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.

Value-Added Programs

The Administrator may offer health or fitness related programs to the Plan's 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 the Plan and could be discontinued at any time. The 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.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact the Plan, either orally or in writing to obtain information on the Plan's Grievance procedures or to file a Grievance with the Plan.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with the Plan on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with the Plan that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, the Administrator must obtain a signed Designation of Representation form from you before the Administrator can deal directly with your representative. The Administrator will forward a Designation of Representation form to you for completion. If the Administrator does not obtain a signed Designation of Representation form, the Administrator will continue to research your Grievance but will respond only to you unless a signed Designation of Representation form is received.

The Administrator will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's appeal.

To obtain information on the Plan's Grievance procedures or to file a Grievance orally with the Plan, please call the toll free Customer Service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about the Plan's Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call the Administrator at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative. The Administrator will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, mail it to: Anthem Appeals, PO Box 33200, Louisville, KY 40232- 3200, ATTN: Appeals Specialist. The Administrator's facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon the Plan's receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from the Administrator), an acknowledgment will be sent to you

within 5 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. The Plan's acknowledgment may be oral for those Grievances the Administrator receives orally. All Grievances will be resolved by the Administrator within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from the Administrator).

If your Grievance cannot be resolved within 20 business days due to the Plan's need for additional information and your Grievance does not relate to an adverse certification decision (i.e., Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from the Plan's original request. In the event of an extension, the Administrator, on behalf of the Employer, will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, the Administrator will make a determination based on the information in the Plan's possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member. Within 5 business days after the Grievance is resolved, the Administrator will send a letter to you notifying you of the decision reached.

Appeals

If the Plan's decision under the Grievance process is satisfactory to you, the matter is concluded. If the Plan's decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of the Plan's receipt of your Appeal request. The Plan's acknowledgment may be oral for those Appeals the Administrator receives orally. The Administrator will set a date and time during normal business hours for the Plan's Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not You choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting, unless your Appeal qualifies for Expedited Review. Appeals concerning adverse certification decisions or the denial of any other prior authorization required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by the Administrator. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by the

Administrator. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by the Administrator of the Plan's decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your Physician believes that the standard appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

The Administrator will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of the Plan's receipt of sufficient information and will communicate the Plan's decision by telephone to your attending Physician or the ordering Provider. The Administrator will also provide written notice of the Plan's determination to you, your attending Physician or ordering Provider, and the facility rendering the service. The Administrator will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. The Plan's decision will be communicated by telephone to your attending Physician or the ordering Provider. The Administrator will also provide written notice of the Plan's determination to you, your attending Physician or ordering Provider, and to the facility rendering the service.

External Grievance

If the Plan's decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

- Your Appeal is regarding:
 1. an adverse determination of appropriateness; or
 2. an adverse determination of Medical Necessity; or
 3. a determination that a proposed service is Experimental/Investigational made by the Administrator or an agent regarding a service proposed by the treating Physician; and
- You or your representative request the External Grievance in writing within forty-five (45) days after You are notified of the Appeal panel's decision concerning your Appeal; and
- The service is not specifically excluded in this Benefit Booklet.

If an External Grievance is requested, the Administrator will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse the Plan's Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization

will notify you and the Administrator of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse the Plan's Appeals decision, the Administrator will notify you or your Provider in writing of the steps the Administrator will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

The Plan expects that you will use good faith to file a Grievance or an Appeal on a timely basis. However, the Administrator will not review a Grievance if it is received by the Administrator after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance. The Administrator will accept Appeals filed within 60 days after you are notified of the Plan's decision concerning your Grievance. The Administrator will accept External Grievance requests filed within 45 days after you are notified of the Plan's Appeal decision.

Grievances and Appeals by Members of ERISA Plans

If you are covered under an Employer plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file a Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while an Appeal is pending. You will be notified of your right to file a voluntary Appeal if the Plan's response to your Grievance is adverse. Upon your request, the Administrator will also provide you with detailed information concerning an Appeal, including how panelists are selected.

GENERAL PROVISIONS

Entire Contract

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Employer and any and all statements made to the Employer by the Plan 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 Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can only be made through an endorsement authorized and signed by a person authorized to sign on behalf of the Employer.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that they, in consultation with their Providers, are responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment recommended by your Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. In this event, the Provider shall have no further responsibility to provide care to you, and the Plan shall have no obligation to have Network Providers available who will render the care.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Plan, disability affecting a significant number of a Network Provider's staff or similar causes, or health care services provided under the Plan are delayed or considered impractical. Under such circumstances, the Plan and Network Providers will provide the health care services covered by the Plan as far as is practical under the circumstances, and according to their best judgment. However, the Plan and Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of the Plan.

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 an 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 the back of your Identification Card.

Coordination Of Benefits

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 the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or

Copayment 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 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, Coinsurance and Copayments, 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 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 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.
7. Any amounts incurred or claims made under the Prescription Drug program of this Plan.

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 of 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 or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by state or 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 state 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.

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 THIS PLAN’S BENEFITS

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is the higher of the Primary and Secondary Plans’ allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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 Administrator, on behalf of the Employer, 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 Administrator needs not tell, or get the consent of, any person to do this. Each person claiming benefits under the Plan must give the Plan any facts it needs 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, the Plan may pay that amount to the organization which 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 the Plan is more than should have paid under this COB provision, the Administrator, on behalf of the Employer, may recover the excess from one or more of the persons:

1. The Plan has paid or for whom the Plan has 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.

Medicare

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Administrator will calculate benefits as if they had enrolled.

Physical Examination

When a claim is pending, the Plan reserves the right to request a Member to be examined by an applicable Provider. This will be requested as often as reasonably required.

Worker's Compensation

The benefits under the Plan are not designed to duplicate benefits that Members are eligible for under the Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to a Member shall be paid back by, or on behalf of, the Member to the Plan if the Plan has made or makes payment for the services received. It is understood that coverage under the Plan does not replace or affect any Worker's Compensation coverage requirements.

Other Government Programs

The benefits under the Plan shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to the Plan.

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your injuries. The following apply:

- The Plan has the first priority for the full amount of benefits it has paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and 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 them.
- The Plan has the right to take whatever legal action it sees fit against any 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 still 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, other expenses or costs without the Plan's prior written consent. The Plan further agrees that 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 apply:

- You must reimburse the Plan to the extent of benefits the Plan paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Plan shall have a right of Recovery, in first priority, against any Recovery.
- 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 to the Plan the amount of your settlement, 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 portion of the amount the Plan has paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan would not have any obligation to pay the Provider.
- 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 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.
- 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.

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 Administrator, on behalf of the Employer, has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer, will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Administrator, on behalf of the Employer, 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 Plan)

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

The Employer is responsible for passing information to the Member. For example, if the Plan gives notice to the Employer, it is the Employer's responsibility to pass that information to the Member. The Employer is also responsible for passing eligibility data to the Plan in a timely manner. If the Employer does not provide the Plan with timely enrollment and termination information, the Plan is not responsible for the payment of Covered Services for Members.

Anthem Blue Cross and Blue Shield Note

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Booklet constitutes a contract solely between the Employer and Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association 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 this agreement.

Conformity with Law

Any provision of this Plan which is in conflict with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Clerical Error

A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or the Plan.

Policies and Procedures

The Employer is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules and interpretations.

Under the terms of the Administrative Services Agreement, the Administrator has the authority, in its sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Benefit Booklet. The Administrator reserves the right to discontinue a pilot or test program at any time. The Administrator will provide advance written notice to the Employer of the introduction or termination of any such program.

Waiver

No agent or other person, except an authorized officer of the Employer, has able to disregard any conditions or restrictions contained in this Benefit Booklet, to extend the amount of 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 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

Anthem 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 Grievances 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. Anthem's determination shall be final and conclusive and may include, without limitation, determination of Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowable Amount. A Member may utilize all applicable Member Grievance procedures.

DEFINITIONS

If a word or phrase in this Benefit Booklet has special meaning, or is a title, it will start with a capital letter. If the word or phrase is not explained in the text where it appears, it will be defined in this section.

If you need additional clarification on any of these definitions, please contact the customer service number located on the back of your ID Card or submit your question online at www.anthem.com.

Actively At Work – An employee who is capable of carrying out their regular job duties and who is present at their place of work. Additionally, Subscribers who are absent from work due to a health related absence or disability and those on maternity leave or scheduled vacation, are considered Actively At Work.

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

Administrator - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator is Anthem Insurance Companies, Inc. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – 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 Administrator, on behalf of the Employer, to be paid at the Network level.

Behavioral Health Conditions –

- **Mental Health Condition** – A display of mental or nervous symptoms that are not a result of any physical or biological cause(s) or disorder(s).
- **Substance Abuse** – A condition that develops when an individual uses alcohol or other drug(s) in a way that damages their health and/or causes them to lose control of their actions.

Behavioral Health Services Subcontractor - An organization or entity that the Plan has a contract with to provide administrative and claims payment services and/or Covered Services regarding Behavioral Health services under the Plan. These administrative services may also be provided directly by the Administrator.

Benefit Booklet- This summary of the terms of your health benefits.

Benefit Period – The length of time that the Plan will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends before this length of time, then the Benefit Period also ends.

Benefit Period Maximum – The maximum that the Plan will pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer’s own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

Copayment – A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. The Copayment does not apply to any Deductible that you are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.

Covered Services - Services, supplies or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under the Plan.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance by the Administrator, on behalf of the Employer, if such Prior Authorization is required in this Benefit Booklet.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission except as otherwise specified in benefits after termination.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by the Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblastic therapy.

Covered Transplant Services - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any Diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which you must pay for before the Plan will pay for those Covered Services in each Benefit Period.

Dependent – A Member of the Subscriber's family who is covered under the Plan, as described in the "Eligibility and Enrollment" Section.

Diagnostic (Service/Testing) – A test or procedure performed on a Member, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a

Member who is not displaying any symptoms. However, this must be ordered by a Provider. Examples of covered Diagnostic Services in the Covered Services section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date that a Subscriber's coverage begins under the Plan. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work.

A Dependent's coverage also begins on the Subscriber's Effective Date.

Eligible Person – A person who meets the Employer's requirements and is entitled to apply to be a Subscriber.

Emergency – An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care - Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

Employer- The legal entity contracting with the Administrator for administration of group health care benefits.

Enrollment Date – The day the Employer or Member signs up for coverage or, when there is a waiting period, the first day of the waiting period (normally the date that employment begins).

Expedited Review – The expedited handling of a Grievance or Appeal concerning the Plan's denial of certification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-Expedited Review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

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 Administrator, on

behalf of the Employer, determines to be unproven. For how this is determined, see the “Non Covered Services/Exclusions” section.

External Grievance- - Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Benefit Booklet.

Family Coverage – Coverage for the Subscriber and all eligible Dependents.

Fee(s)- The periodic charges which are required to be paid by you and/or the Employer to maintain benefits under the Plan.

Formulary - The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

Generic Drugs – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

Grievance - Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or Medically Necessary;
- a determination that a proposed service is Experimental/Investigative;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan or the Employer and the Plan.

Identification Card / ID Card – A card issued by the Plan, showing the Member’s name, membership number, and occasionally coverage information.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. This does not apply to a Member who is placed under observation for fewer than 24 hours.

Late Enrollee – An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under the Plan, and who did not qualify for Special Enrollment.

Lifetime Maximum – The maximum dollar amount the Plan will pay for Covered Services during your lifetime. While Prescription Drugs do not accumulate toward the Lifetime Maximum, once the Lifetime Maximum has been reached, no additional benefits for Prescription Drugs will be paid.

Mail Service – The Anthem Prescription Management program which offers you a convenient means of obtaining maintenance medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with the Administrator, and sent directly to your home.

Maximum Allowable Amount -- The maximum amount that the Plan will pay for Covered Services you receive. For more information, see the “Claims Payment” section.

Medically Necessary/ Medical Necessity - 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 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 mean lowest cost);
- 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.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required Fee payment; Members are sometimes called “you” or “your” in this Benefit Booklet.

Network Provider – A Provider who has entered into a contractual agreement or is being used by the Administrator, or another organization, which has an agreement with the Administrator, to provide Covered Services and certain administration functions for the Network associated with the Plan.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Provider - A Provider that has been designated as a “center of excellence” by the Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee. 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.

New FDA Approved Drug Product or Technology - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations: a new dosage form or new formulation of an active ingredient already on the market;
- Already marketed Drug product but new manufacturer: a product that duplicates another firm’s already marketed Drug product (same active ingredient, formulation, or combination);
- Already marketed Drug product, but new use: a new use for a Drug product already marketed by the same or a different firm; or
- Newly introduced generic medication: generic medications contain the same active ingredient as their counterpart brand-named medications.

Non-Network Provider - A Provider who has not entered into a contractual agreement with the Administrator for the Network associated with the Plan. Providers who have not contracted or affiliated with the Plan’s designated Subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement nor is otherwise engaged by to render Specialty Drug Services, or with another organization which has an agreement with the Administrator, to provide Specialty Drug services to you for the Specialty Pharmacy Network.

Non-Network Transplant Provider - Any Provider that has **NOT** been designated as a “center of excellence” by the Administrator or has not been selected to participate as a Network Transplant Provider by a designee.

Open Enrollment – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; See Eligibility and Enrollment section for more information.

Out of Pocket Limit - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this Benefit Booklet and/or the Schedule of Benefits.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Pharmacy and Therapeutics (P&T) Committee – A committee consisting of health care professionals, including Nurses, Pharmacists, and Physicians. The purpose of this committee is to assist in determining clinical appropriateness of Drugs; determining the assignments of Drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

Plan – The group health benefit plan provided by the Employer and explained in this Benefit Booklet.

Prescription Order – A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Prescription Legend Drug, Prescription Drug, or Drug – A medicinal substance that is produced to treat illness or injury and is dispensed to Outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, “Caution: Federal law prohibits dispensing without a prescription.” Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under the Plan.

Primary Care Physician (“PCP”) – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T Committee.

Provider – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID card.

- **Alcoholism Treatment Facility** - A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternative Care Facility** – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:
 1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
 2. Surgery
 3. Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** - A facility, with an organized staff of Physicians, that:
 1. Is licensed as such, where required;
 2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
 3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
 4. Does not provide Inpatient accommodations; and
 5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Certified Advance Registered Nurse Practitioner**
- **Certified Nurse Midwife**
- **Certified Registered Nurse Anesthetist**
- **Certified Surgical Assistant**
- **Day Hospital** - A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility** - A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.
- **Drug Abuse Treatment Facility** - A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency** - A facility, licensed in the state in which it is located, which:
 - Provides skilled nursing and other services on a visiting basis in the Member's home; and
 - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Home Infusion Facility** - A facility which provides a combination of:
 1. Skilled nursing services
 2. Prescription Drugs
 3. Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.
- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
 1. Provides room and board and nursing care for its patients;
 2. Has a staff with one or more Physicians available at all times;
 3. Provides 24 hour nursing service;
 4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
 5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care

6. Educational care
7. Treatment of alcohol abuse
8. Treatment of drug abuse

- **Laboratory (Clinical)**
- **Licensed Practical Nurse**
- **Licensed Professional Counselors**
- **Occupational Therapist**
- **Outpatient Psychiatric Facility** - A facility which mainly provides Diagnostic and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.
- **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 a Non-Network Provider.
- **Physical Therapist**
- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).
- **Psychiatric Hospital** - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Registered Nurse First Assistant**
- **Registered Nurse**
- **Registered Nurse Practitioner**
- **Regulated Physician's Assistant**
- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the

combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified)**
- **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.
- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:
 1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
 2. provides care supervised by a Physician;
 3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
 4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
 5. is not a rest, educational, or custodial Provider or similar place.
- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
- **Speech Therapist**
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**
- **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any “Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Service Area – The geographical area where Our Covered Services are available, as approved by state regulatory agencies.

Single Coverage – Coverage that is limited to the Subscriber only.

Special Enrollment – A period of enrollment in which certain Eligible Persons or their Dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc.

Specialty Care Physician (SCP) - A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Stabilize - The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor – We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs and Behavioral Health services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber - An employee or Member of the Employer who is eligible to receive benefits under the Plan.

Therapy Services – Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.

FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENTS, OR BILLINGS

CUSTOMER SERVICE NUMBER

Business Hours are 8:00 A.M. to 6:00 P.M.

Medical Questions –1-877-814-9709

PRECERTIFICATION

1-877-814-4803

MENTAL HEALTH OR SUBSTANCE ABUSE PROGRAM

1-800-223-7723

EMPLOYEE ASSISTANCE PROGRAM

1-800-223-7723

PHARMACY NETWORK

1-800-662-0210

**PLEASE HAVE YOUR IDENTIFICATION NUMBER READY
WHEN YOU CALL**

ADVANTAGE HEALTH SOLUTIONS, INC.

CERTIFICATE OF COVERAGE

Group:			
Policy #:		Group Contract Eff:	01/01/2009
Member ID #: As Shown on ID Card			
Policy maximum:	Unlimited See definition		
Deductible:			
<p>Except where indicated, benefits are subject to a \$250 <i>deductible</i> per member, per calendar year.</p> <p>Covered services for outpatient prescription drugs are subject to a: \$100 <i>deductible per single and \$200 deductible per family</i> on all Brand Name Drugs per member per calendar year this excludes Diabetic Supplies.</p> <p>All <i>Covered Service</i> are subject to the <i>Policy maximum</i> applicable to each <i>member</i>.</p>			
New Hire Eligibility:			
New hires shall become effective on the first (1 st) of the month following 45 days of employment.			
Dependent Age Limit:			
Unmarried children are eligible to the last day of the year in which the child reaches age 24. Any Young Adult child age 19 up to the day of the 24 th birthday., regardless of marital status, is eligible for coverage under the Young Adult Rider if the Young Adult is: (1) the natural or adopted children of the subscriber; or (2) the stepchild, grandchild, or other blood relative of the subscriber and the subscriber pays more than 50% of the Young Adult's total support; or (3) the subscriber is the Young Adult's legal guardian and the subscriber pays more than 50% of the Young Adult's total support.			

IMPORTANT CONTACTS

(You write the name, address and phone number of your Primary care physician (PCP) in the spaces provided below)

Your PCP: _____
Address: _____
Telephone: _____

Spouse's PCP: _____
Address: _____
Telephone: _____

Dependent's PCP: _____
Address: _____
Telephone: _____

Dependent's PCP _____
Address: _____
Telephone: _____

ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE) :

Member Services or Eligibility Department

P.O. Box 80069
Indianapolis, IN 46209
(317) 573-6228 or 1-800-553-8933
TDD: 1- 800 743-3333 (hearing impaired)
Monday-Friday, 7:30 am to 5:30 pm
FAX: (317) 573-2839
NOTE: To ensure quality service, your call may be monitored.

**TDD (for hearing impaired)
1-800-743-3333**

Appeals Specialist

9045 River Road, Ste 200
Indianapolis, IN 46240
(317) 573-6689 or 1-888-806-1029
TDD: (800) 743-3333 (hearing impaired)
Monday-Friday, 8:00 am to 5:00 pm
FAX: (317) 573-7403 or 1-866-510-7765

**Anti-Fraud Help Line:
1-888-333-9576**

Web site
www.advantageplan.com

Health Promotion Coordinator

9045 River Road, Ste 200
Indianapolis, IN 46240
(317) 573-2922 or 1-888-824-0391
TDD: 1-800 743-3333 (hearing impaired)
Monday-Friday, 8:00 am to 5:00 pm
FAX: (317) 573-2841 or 1-888 771-4905

If you have limited use and/or understanding of English, ADVANTAGE will provide interpreter services to you or your representative through the AT&T Language Line Services. This service provides immediate access to interpreter services in 150 languages. If you are hearing impaired, ADVANTAGE will provide interpreter services through the Telecommunications Relay System. Interpreter services are available at no charge to you.

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SECTION 1: WELCOME TO ADVANTAGE

This *Certificate of Coverage* and *Member Handbook (Certificate)* explains *your* health care benefits under ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE). It describes the rules of ADVANTAGE, how to access medical care, what health care services are covered under ADVANTAGE, and what portion of the health care costs *you* will be required to pay.

This *Certificate* is part of the *Group Services Agreement (Agreement)* between ADVANTAGE and *your* employer group (*Group*). The *Agreement* sets the terms and conditions of *coverage*. This *Certificate* describes the health care *covered services* for *you* and *your eligible dependents*. The *coverage* described in this *Certificate* is subject in every respect to the provisions of the *Agreement* issued to *your Group*. If there is any conflict between the *Agreement* and this *Certificate*, the *Agreement* shall prevail.

Please read this *Certificate* in its entirety so that *you* will know how to get the most out of *your* health care benefits and understand *your* responsibilities. In order to provide *you* with clear information, many words in this *Certificate* have special meanings. These words appear in *italics* type and have been defined for *you* within the body of this *Certificate* or in the Glossary of Terms section at the end of this *Certificate*. The terms “*you*,” “*your*” and “*yourself*” refer to the *member*, whether enrolled with ADVANTAGE as a *subscriber* or *eligible dependent*.

Our Company

ADVANTAGE is a health maintenance organization organized and licensed in the State of Indiana. ADVANTAGE’s strategy is to serve the growing number of *Groups* and the public sector in Indiana that seek to control health care costs and manage employee health benefit plans through the offering of quality managed care products.

ADVANTAGE is an institution operated in accordance with the *Ethical and Religious Directives* for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. ADVANTAGE is not required to provide services that are inconsistent with the medical ethics or precepts of the Catholic Church.

Our Mission

ADVANTAGE will be a statewide leader in managed care, offering access to a broad community-based and high-quality delivery system of *providers*; affordable and comprehensive benefit plans; high quality service to our customers; and a corporate environment that fosters physical, mental and spiritual health for our employees.

Based on the core values of fidelity, excellence and quality, dignity of persons, and stewardship, ADVANTAGE will continuously strive to enhance the health of our communities through public-private partnership initiatives, a firm company commitment to volunteerism and the belief that...

- Life is enriched through the delivery of compassionate care
- Each person is respected as having intrinsic worth
- In all matters, honesty and integrity, and
- Common beliefs, mission and values that are supported by our Catholic owners’ best serve ADVANTAGE.

Should *you* have any questions, please call Member Services toll-free at 1-800-553-8933 or (317) 573-6228. We are pleased that *you* have chosen ADVANTAGE and look forward to serving *you*.

ALWAYS REMEMBER. . .

- To show *your* ADVANTAGE member ID card every time *you* check in at an appointment.
- Tell *your Group* within 31 days when *you* have a newborn or adopted child.
- Everyone in *your* family should choose a doctor. This doctor will be *your primary care physician (PCP)*. Each family member may choose a different *PCP*.
- If *you* do not choose a *PCP*, ADVANTAGE will choose one for *you*.
- *Your PCP* belongs to a *provider network*. *You* must receive all non-emergency care through *your PCP’s provider network*.
- Once *you* choose a *PCP*, *you* should make an appointment to get to know him.
- If *you* miss a scheduled appointment without canceling ahead of time, the doctor may charge *you* for the missed appointment.
- If *you* change to a different *PCP*, it is important to ask the new doctor which *hospitals* and specialists *you* should use.
- If *you* feel *you* have a medical emergency, and if there is time, *you* should call *your PCP* for advice and instructions. If *you* feel that the emergency puts *your* life in danger or could cause a serious disability or is a major threat to *you* or one of *your* family members, *you* should go to the nearest emergency room or call 911.
- If *you* use the emergency room for non-emergency care that is not approved, *you* will be responsible for the bill.
- If *you* have a student dependent, all non-emergency care must be authorized by the student’s *PCP*.
- To keep *your PCP* informed of medications prescribed by specialty care *providers* or behavioral health *providers* to prevent adverse drug reactions.

YOUR RIGHTS AND RESPONSIBILITIES

You, *your physician* and other health care *providers* are partners in *your* health care. There are certain rights and responsibilities that are critical to this partnership. The manner in which *you* exercise these rights and responsibilities affects our ability to make appropriate medical care available to all our *members*. *You* are entitled to these rights without regard to sex, race, culture, and economic, educational or religious background.

You Have the Right...

- To select a *Primary care physician (PCP)* and to change *your Primary care physician* one time a year by contacting Member Services
- To have twenty-four (24) hour access to *your PCP* and if out of town, receive emergency care if necessary
- To receive prompt and appropriate treatment for physical and emotional disorders and disabilities in the least restrictive environment necessary for that treatment, and remain free from unnecessary or excessive medication
- To be informed by *your health care provider* of information about *your* diagnosis, treatment and prognosis in a manner that *you* can understand.
- To participate in decisions involving *your* medical care, *you* should receive enough information to enable *you* to make an informed decision before *you* receive any recommended treatment. The information should include a candid discussion of appropriate or *medically necessary* treatment options for conditions, regardless of cost or benefit *coverage*
- To receive information on early *hospital* discharge and follow-up care, rehabilitation and living arrangements that are available once *you* are released from the *hospital*
- To receive appropriate information so *you* may give an informed, voluntary consent to participate in any *experimental* research. (*Experimental* and *investigational* procedures are not covered under *your* Plan.)
- To refuse treatment and to be informed of the probable consequences of *your* action
- To have *your* guardian, next of kin or legally authorized person exercise *your* rights on *your* behalf if *your* medical condition causes *you* to be incapable of understanding or exercising *your* rights
- To know the cost of *your* care and treatment and to receive an explanation of *your* financial responsibility upon request
- To have *your* health records kept confidential except when disclosure is required by law or permitted by *you* in writing. *You* have the right to review *your* medical records with *your Primary care physician* after adequate notice has been given
- To receive guidance and recommendations for additional medical care when *coverage* ends
- To be provided with information about *your* Plan, its *providers* and *your* rights and responsibilities
- To provide opinions about ADVANTAGE or the care provided by *your* health care *provider* and to recommend changes in policies and services by contacting Member Services
- To be informed about the *grievance* procedures
- To voice complaints or appeals about ADVANTAGE or the care *you* have received and to receive a response to complaints or appeals within a reasonable amount of time
- To be treated with respect and recognition of *your* dignity and right to personal privacy
- To receive advice or assistance in a prompt, courteous and responsible manner
- To review the criteria utilized to make an adverse decision regarding any services requested but denied by our medical management department
- To continue receiving active treatment from *your provider* even if the *provider's* network status changes (i.e. terminates from the network) until the current treatment period ends or up to 90 days, whichever is shorter
- To make recommendations regarding ADVANTAGE's *member* rights and responsibilities policies

You Have the Responsibility . . .

- To keep scheduled appointments and give adequate notice of appointment delay or cancellation
- To be considerate of other patients and to be understanding and tolerant if any delays should occur
- To provide, to the extent possible, information that ADVANTAGE and its *providers* need in order to care for *you*
- To communicate openly with the *provider* and medical staff. If *you* have questions or disagree with the treatment plan, *you* have the responsibility to discuss *your* concerns with the medical staff and make certain *you* understand the explanations and instructions
- To be honest, complete and accurate when providing information to the medical staff
- To follow the instructions and guidelines given to *you* by the medical staff and to consider the potential consequences if *you* do not comply
- To follow the plans and instructions for care that *you* have agreed upon with *your providers*
- To understand *your* health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- To understand what medications *you* are taking and whether follow-up care is needed
- To know how to access care in emergency, urgent and routine situations
- To express *your* opinions, concerns, or complaints in a constructive manner to the appropriate personnel with ADVANTAGE or *your network provider*
- To know the benefits and *non-covered services* of *your coverage*
- To contact Member Services for all questions and assistance
- To treat all ADVANTAGE and *provider* personnel in a courteous and respectful manner

SECTION 2 – SELECTING A PRIMARY CARE PHYSICIAN (PCP):

You must select a PCP for you and each eligible dependent. You must live or work within thirty (30) air miles of the PCP you select. Each eligible dependent of your family may select a different PCP. When selecting a PCP, keep in mind you may want to select a physician that best meets your health care and cultural needs. Each PCP belongs to a provider network that includes hospitals, specialists (SCPs) and other health care providers. When you choose a PCP, you also choose the provider network.

You can find a list of hospitals and SCPs included in your PCP's network in the Provider Directory, or visit ADVANTAGE's web site at www.advantageplan.com.

What is the role of a PCP?

Your PCP is your primary health care provider responsible for coordinating all of your health care needs. It is very important that you establish a relationship with your PCP as soon as possible. Your PCP needs to be familiar with your health care needs in order to properly manage your care. For your safety and well-being, you are encouraged to discuss all of your health care services with your PCP, including specialty care, prescriptions, medical history, etc. If you have selected a PCP who has not been providing care for you, we encourage you to contact him/her as soon as possible.

How do I schedule an appointment with my PCP?

Call the PCP's office to schedule an appointment. Always identify yourself as an ADVANTAGE member.

Please follow these scheduling tips:

- Always schedule routine visits in advance
- Always have your member ID card available.
- If a copayment or coinsurance is required, you will be asked to make that payment at the time of your visit. The copayment or coinsurance amount is shown on your member ID card.
- If you are unable to keep an appointment with your physician, please call your physician's office at least twenty-four (24) hours in advance of your appointment time to cancel.

ADVANTAGE ensures you can obtain health care services in a timely manner for preventive, routine and urgently needed services. The ADVANTAGE appointment standards for primary care are:

- Routine preventive care appointments 30 business days
- Routine primary care appointments 10 business days
- Urgent care appointments 48 hours
- Emergency care appointments Immediate
- After-hours access 7 days/week; 24 hours/day
- Wait time in physician office Not to exceed 30 minutes

If your PCP is not available for your appointment and you are seen by a partner or on-call physician, you will only be responsible for the physician office visit copayment or coinsurance shown on your ID card.

NOTE: Members, who miss scheduled appointments, without canceling with reasonable notice, may be charged by the provider for missed appointments.

What do I do if I need medical services after my PCP's normal office hours?

If you must reach your PCP after normal office hours, you may do so by calling the PCP's telephone number listed on your ID card. You may be uncertain if you should call the PCP immediately or wait until normal office hours. Remember, routine questions and problems should be handled during normal business hours. Examples of routine questions or problems may include:

- Scheduling appointment for physical exam
- Requesting information regarding your child's vaccinations
- Non-emergency conditions, such as:
 - Cold or flu symptoms
 - Muscle sprain
 - Skin rash
 - Earache
 - Other symptoms or conditions that do not require immediate medical treatment

If you feel you should speak with the physician immediately, call the PCP's telephone number and follow the instructions provided to you by the after-hours answering service.

What if I want to change my PCP?

You and your eligible dependents may change to a different PCP anytime, unless you are under acute treatment and care, or you can change to a different PCP during your open enrollment period. To change to a different PCP, please refer to the Provider Directory to be sure that the PCP you select is accepting new patients. To change to a different PCP, you may contact the ADVANTAGE Member Services Department by phone or visit our website at www.advantageplan.com. See Important Contacts located at the front of this Certificate. Your new PCP selection will become effective the first of the following month after we receive your request for change.

A new *ID card* will be mailed to *you* and any of *your eligible dependents* that have changed *PCPs*. It is important to review the *PCP* information on *your ID card* to verify that the *PCP* listed on the card is the *PCP* you selected.

When you select a new *PCP* from a different *provider network*, it is important that you understand that the *hospital*, *SCPs*, ancillary services, and *behavioral health providers* associated with that *provider network* may be different.

SECTION 2A – SPECIALTY CARE SERVICES:

What are the covered services?

Except for services and items listed as *non-covered services* in this *Certificate*, *covered services* include those services for consultation or treatment by a *SCP*, which are *medically necessary*.

What is a specialty care physician (SCP)?

A *physician* whose training has been concentrated in a specialized field is considered a *SCP*. Examples of *SCPs* would include surgeons (orthopedic, cardiovascular, vascular, etc.), cardiologists, oncologists, urologists, etc. For mental health and substance abuse services, please read the information in the Behavioral Health section of this *Certificate*.

What do I do when I need to see a SCP?

You can self-refer to the appropriate *SCP* in *your PCP's provider network* for office visits and consultations. If the *SCP* schedules you for any procedures or special treatment, the services may require *prior authorization*. Please ask the *SCP* to contact *ADVANTAGE*.

ADVANTAGE ensures you can obtain health care services in a timely manner for specialty services. The *ADVANTAGE* appointment standards for specialty care are:

- Non-Urgent Within 20 business days
- Urgent complaints Within 48 business hours
- Emergency Care Immediate
- After-hours access 7 days/week; 24 hours/day
- Wait time in *physician* office Not to exceed 30 minutes

What if my physician wants to refer me to a SCP outside the provider network?

Your physician may determine you require treatment by a type of *SCP* that is not available in *your provider network*. When your *physician* refers you to a provider outside of the *provider network*, be sure you or your physician contacts *ADVANTAGE* prior to your appointment to ensure your benefits are paid correctly.

IDENTIFICATION CARD

Your actual *ID card(s)* will be mailed to you in a separate envelope. Each *eligible dependent* is provided with a separate *ID card*. If you need replacement *ID cards*, call Member Services at 1-800-553-8933 or (317) 573-6228. Also, you can request a replacement card or print a temporary *ID card* by visiting our website at www.advantageplan.com.

Your *ID card* provides important information regarding your *copayments* and *coinsurance* (if any) for *physician* office visits, *emergency* and *urgent care* visits, and *hospital coverage*. Your *PCP* name and office telephone numbers are provided on the card. You should always carry your *ADVANTAGE ID card* with you. The card also has other very important information that you and your *physician* will need.

Please note that any claims you may receive should be directed to the "Claims Address" shown on the card.

SECTION 3: ENROLLMENT, ELIGIBILITY AND

COVERAGE INFORMATION

You must enroll yourself and members of your family who are eligible dependents during your Group's open enrollment period. The initial open enrollment period will be held for a period no longer than 31 days and will be closed prior to the effective date of the Agreement with your Group. Subsequent open enrollment periods will be held at least annually for a period of not more than 31 days, beginning on a date agreed to by the Group and ADVANTAGE and closing prior to the renewal date. During an open enrollment period, any eligible person and/or eligible dependent may join ADVANTAGE.

By enrolling in this Plan, you understand that ADVANTAGE has the right to utilize your personal medical information for future, known or routine needs for the purposes of treatment, payment, and health care operations. This may include: coordination of care; case management; disease management; quality assessment and measurement; accreditation; decisions about the payment of services; and other normal business operations related to administering the health plan. Information may be transmitted to or from ADVANTAGE for the purpose of arranging for your health care and benefits. **You understand this consent is a condition of your enrollment in ADVANTAGE and you have the right to revoke this consent in writing at any time. You also understand you have the right to file a grievance if you feel there is a violation regarding use or disclosure of your personal health information.**

A person who previously had coverage voided under ADVANTAGE because of: fraud; misrepresentation; misusing an ID card; or failure to make payment, unless payment has since been made in full; may not enroll in ADVANTAGE.

Who can be covered under dependent coverage?

- Your legal spouse
- Any unmarried children dependent upon you for support through the age specified on the cover page to this Certificate.
- Disabled *eligible dependents* already enrolled and are incapable of self-supporting due to mental retardation or physical handicap and are chiefly dependent upon the subscriber or subscriber's spouse for support and maintenance at the time he or she reaches the limiting age may remain a covered *eligible dependent for the duration of the disability and dependency*. ADVANTAGE must certify the dependent's eligibility under a disability status. ADVANTAGE must be informed of the dependent's eligibility for continuation of coverage within 120 days after the dependent reaches the limiting age and subsequently, at reasonable intervals during the two years following the dependent's attainment of the limiting age. ADVANTAGE may require proof once per year in the time following the two year period after the dependent's attainment of the limiting age. The proof must include a statement by a licensed psychologist, psychiatrist, or other physician and proof of continued dependency. ADVANTAGE requires such proof of the person's disability/dependency within 30 days of the request.

If a dependent of the subscriber or spouse who attained the limiting age while covered under another health care policy meets the criteria specified above, the dependent is an *eligible dependent* for enrollment so long as no break in coverage longer than 63 days has occurred immediately prior to enrollment. ADVANTAGE will require proof of disability as described above.

- **Court-Ordered Coverage:** A court or administrative agency of competent jurisdiction orders you or your family members to provide health coverage for a child under age 18. The child may be enrolled by his custodial parent; his non-custodial parent; the office of Medicaid Policy and Planning; or a Title IV-D agency. The date of status change is the date the order is issued.

If you are required by a Qualified Medical Child Support Order or court order, as defined by the Employee Retirement Income Security Act or applicable state law, you may enroll your child in ADVANTAGE without regard to any enrollment limits. Your child will be eligible to receive the covered services described in this Certificate in accordance with the requirements of such order. A child's coverage under this provision will not extend beyond the age limits described on the cover page of this Certificate. Any claims payable under this Certificate will be paid at our discretion to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. ADVANTAGE will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

NOTE: Enrollment is allowed any time after the order is issued. The amount *you* must contribute toward the *premium* fee may increase when *your* newly *eligible dependent* is added.

- Who is eligible for coverage under the Young Adult Coverage Rider?
 - A *Young Adult*, regardless of marital status, between the ages of 19 and 24 can be covered on the *Young Adult Coverage Rider* if the *Young Adult* meets any of the following criteria:
 - (1) the natural or adopted child of the subscriber;
 - (2) the step-child, grandchild, or other blood relative of the subscriber and the subscriber pays more than fifty percent (50%) of the *Young Adult's* total support; or
 - (3) The subscriber is the *Young Adult's* legal guardian and the subscriber pays more than fifty percent (50%) of the *Young Adult's* total support.
 - The *Young Adult's* coverage is a Rider to the subscriber coverage with ADVANTAGE, it is not individual coverage. If the subscriber's coverage terminates for any reason, coverage under the *Young Adult Rider* terminates.
 - A *Young Adult* may elect coverage at open enrollment. If a group does not have an annual open enrollment the *Young Adult* may elect coverage upon renewal of the group contract.
 - For a *Young Adult* that is entitled to a *Special Enrollment Period*, the provisions for all *Special Enrollment Periods* apply.
 - Medical care for a *pre-existing condition* of a *Young Adult* may be subject to a six (6) month limitation of benefits as provided in Section 5 of this *Certificate*.
 - A *Young Adult* may not enroll his/her spouse or children.

What do I do when there is a change in my family status?

In order to avoid problems for proper claims payments, it is very important that *you* let *your Group* know of any and all changes in *your* family status. Examples of family status changes include:

- Marriage – *you* must notify your employer within 31 days from the date in which you married that you wish to enroll your spouse in ADVANTAGE for coverage.
- Newly Adopted Child - Adopted children are eligible for *coverage* as of the earlier date of placement with *you* and/or *your spouse*, or the date of the entry of the order granting the adopting parent custody of the child for purposes of adoption. The adopted child is automatically entitled to receive *covered services* for the first 31 days as of earlier date of placement with *you* and/or *your spouse*, or the date of entry of the order granting the adopting parent custody of the child for purposes of adoption. In order for *coverage* to continue beyond the first 31 days, *you must notify your employer that you wish to enroll the child in ADVANTAGE for coverage to continue beyond the first 31 days.* If *you* do not notify *your Group* within 31 days, then the rules applicable to *late enrollees* apply, as discussed later in this *Certificate*. In that case, *you*, not ADVANTAGE, will be responsible for payment of services, which were provided to the child after the 31st day.
- Birth of a child - A child newly born to *you* or to *your enrolled eligible dependent*, or adopted by *you* within 31 days of birth, is automatically entitled to receive *covered services* for the first 31 days from date of birth. **Within 31 days of birth, you must notify your employer that you wish to enroll your newborn in ADVANTAGE for coverage to continue beyond the first 31 days.** If *you* do not notify *your Group* within 31 days, the child will be declared ineligible for covered services after 31 days from date of birth. In that case, *you*, not ADVANTAGE, will be responsible for payment of services, which were provided to the child after the 31st day. Nor will ADVANTAGE arrange or provide for the child's care after the 31st day in that case. If newborn is not a child born to *you* or *your spouse*, or is not covered as an adopted child or guardian situation, then newborn shall not be eligible for *coverage* beyond the 31st day. If *you* do not notify *your Group* within 31 days, then the rules applicable to *late enrollees* apply, as discussed later in this *Certificate*.
- Guardianship – Children under the guardianship of *you* or *your spouse* are eligible for *coverage* as of the earlier of:
 - the date of placement with *you* or *your spouse*, or
 - The *effective date* of guardianship under *you* or *your spouse*.
 - The enrollment process and applicable *premium* payment must occur within 31 days of either the placement or date of the legal guardianship for *coverage* to continue beyond the first 31 days. If the child is not enrolled within the 31 days, then the rules applicable to *late enrollees*, as described later in this *Certificate*, apply.
- Court-Ordered Guardianship - A court newly-orders an *eligible dependent* under *your* legal guardianship. The date of status change is the date the court order is issued
- A child who marries or reaches the *dependent* age limit - *Coverage* for *your eligible dependent* child will end without notice when *your eligible dependent* marries or reaches the limiting age as described on the cover page of this *Certificate*. If your dependent loses coverage due to dependent age limits and/or marries and you wish to continue coverage under the Young Adult Coverage

Rider, once that child meets the definition of *Young Adult* you must notify your employer that you wish to obtain the Young Adult Coverage Rider within 31 days of the dependent reaching the limiting age.

NOTE: If both parents are *subscribers*, only one parent can enroll the child as an *eligible dependent*. No one will be refused enrollment or re-enrollment because of: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of violence; or disability.

A *subscriber* and a *spouse* working for the same *Group* cannot be both *subscriber* and *dependent*.

The requirements of this *Certificate* will apply equally to *you* and to *your* enrolled *eligible dependents*, except when there is a change in *your* family status as described above.

All benefits and privileges made available to *you* shall be available to *your* enrolled *eligible dependents* except for:

- *eligible dependent* children who marry may not enroll their *spouses* and they cease to be eligible for *coverage* as an *eligible dependent*;
- when required by law, a minor *dependent* may not convert to *Individual Conversion Contract*, other than as an *eligible dependent* of an adult *subscriber*.

Late enrollees - A *late enrollee* is a *subscriber* or *eligible dependent* who did not request enrollment in *ADVANTAGE*:

- During the initial enrollment period in which he/she was first entitled to enroll; or
- During any special enrollment period, as provided in this *Certificate*.

The term “*late enrollee*” does not include:

- A *subscriber* or *eligible dependent* who:
 - was covered under another health insurance *carrier* or had other health insurance at the time *ADVANTAGE* was previously offered to him/her; and
 - requests enrollment within 31 days after losing that other health insurance due to:
 - exhausting his/her COBRA benefits;
 - loss of eligibility for the other health insurance, including as a result of legal separation, divorce, death, termination of employment, or reduction in work hours;
 - termination of *Group* contributions toward other health insurance.
- A *subscriber* who:
 - is employed by an *Group* that offers multiple health insurance *carriers*; and
 - elects a different *carrier* during an *open enrollment period*.
- A *subscriber* and his/her *spouse*, minor child, or *eligible dependent* child, when:
 - a court orders that health insurance for the *spouse*, minor child, or *eligible dependent* child be provided under *ADVANTAGE*; and
 - enrollment is requested within 31 days after the order was issued.
- A child under age 18, when a court orders the *subscriber* or an *eligible dependent* to provide health insurance for the child.
- A *young adult*

A *late enrollee* may request enrollment at any time. The *coverage* will become *effective* on the next *renewal date* or at the end of 12 months after the date enrollment is requested; whichever occurs first.

Special Enrollment Periods

If *you're eligible dependent* or a *young adult* did not enroll with *ADVANTAGE* when *you* enrolled due to other *coverage*, and that *eligible dependent* has since lost the other *coverage*, *your eligible dependent* or *young adult* does not have to wait until *your Group's* next *open enrollment period*. They are entitled to a special enrollment period.

- *You* must request a special enrollment period within thirty (30) days from the date *your eligible dependent* loses the other *coverage*.
- If *your eligible dependent's* other *coverage* is through COBRA, special enrollment can only be requested after the COBRA continuation *coverage* is exhausted (Refer to the Continuation of Coverage Section of this *Certificate* for an explanation of COBRA *coverage*).
- Special enrollment period can only be requested after losing eligibility for the other *coverage* or after *Group* contributions have stopped.

An employee who loses *coverage* is effective on the first day of the month following the date the employee submits the election form to the *Group*.

Special enrollment period also occurs if *you* have a new dependent by birth, marriage, adoption or placement for adoption. If *you* are an *ADVANTAGE subscriber*, *your* newly acquired *spouse* may become enrolled with *ADVANTAGE* by the first of the following month. If *you* are an eligible employee and not an *ADVANTAGE subscriber*, *your* newly acquired *spouse* can be enrolled together with *you* when *you* marry or when a child is born, adopted or placed for adoption. A child who becomes *your dependent* as a result of marriage, birth, adoption or placement for adoption can be enrolled if *you* enroll at the same time. Refer to the Enrollment, Eligibility and Coverage Information section of this *Certificate*. The election to enroll newly acquired dependents under special enrollment must be made within thirty (30) days following the birth, marriage, adoption, or placement for adoption.

If *you* are an eligible employee who is an *ADVANTAGE subscriber* *you* are not eligible for “special enrollment.” However, *your* new spouse, newborn or newly adopted child is eligible for special enrollment. These new dependents must be enrolled in the same product option in which *you* are currently enrolled.

What do I do if my name or address changes?

If *your* name or address changes, it is very important that *you* notify *your Group* as soon as possible. *Your Group* will notify *ADVANTAGE*, at which time, *your* records will be updated.

Other Rules of Enrollment

Service area

ADVANTAGE defines *service area* as the 30 air mile radius surrounding the *PCP* selected by *you*. With the exception of a full-time student as described in this *Certificate*, *you* and *your eligible dependents* must select a *participating PCP* within 30 air miles of *your* permanent residence or place of employment. If *you* change *your* permanent residence or place of employment, and *you* no longer live or work within a 30 mile radius of *your* assigned *PCP*, *you* must select a new *participating PCP*. If there is no *participating PCP* in the *Provider Directory* available within 30 air miles of *your* new residence or place of employment, then *you* should contact *your Group* to determine if other *coverage* is available. An absence from the *service area* for more than ninety (90) consecutive days will be considered a change in permanent residence, unless otherwise indicated by *your Group*. *You* must notify *ADVANTAGE* of any move or extended absence from the *service area*. Failure to notify *ADVANTAGE* of a move or extended absence may result in *your* having to pay for services obtained outside of the *service area*. Should *you* have questions regarding *service area* requirements, please contact *ADVANTAGE*'s Member Service Department.

Non-Custodial Parent

Whenever a child of a non-custodial parent has *coverage* with *ADVANTAGE*, the custodial parent may receive information that is necessary for the child to obtain *covered services*. However, *ADVANTAGE* will not be obligated to provide information to the custodial parent unless *ADVANTAGE* is provided with the correct address. The custodial parent will be entitled to submit claims to *ADVANTAGE* or the *provider network* for payment to be made to *providers* for *covered services*.

SECTION 4: COVERED SERVICES – BENEFITS

Each *covered services* category is shown with any applicable *copayment, deductible, or coinsurance* for which you are responsible to pay at the time of service. All *covered services* are subject to the conditions, exclusions, limitations, terms and provisions explained in this *Certificate*, including any attachments. All *copayments, deductibles and coinsurance* in effect at the time of service will apply to all *covered services*. **Please refer to Section 5, Other Non-covered services and Limitations on Benefits for additional explanation of the specific services not covered under this Certificate.**

You are entitled to the *covered services* listed in this section when those services meet the following criteria:

- Services are *medically necessary*; and
- Services are provided or *authorized* by your *PCP*; and
- Services are not excluded elsewhere in this *Certificate*
- Except for *emergency services* and services otherwise *authorized* by your *PCP*, all *covered services* must be obtained from *participating providers*.

Prior Authorization

Certain services require prior *authorization* before obtaining those services. For a list of services that require prior *authorization* please refer to your Member Reference Guide, contact *ADVANTAGE* Member Services Department by phone or log onto www.advantageplan.com via the internet. *Member* is responsible for obtaining all prior *authorizations* as indicated in the Member Reference Guide.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Allergy Tests and Procedures		
• Serum		50% <i>coinsurance</i>
• Administration of serum	Refer to <i>Physician Services</i> benefit	Refer to <i>Physician Services</i> benefit
• Allergy testing	Refer to <i>Physician Services</i> benefit	Refer to <i>Physician Services</i> benefit

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Ambulance Transportation		
<i>Ambulance</i> transportation is covered for <i>emergency service</i> . Other <i>medically necessary ambulance</i> transport is covered when <i>authorized</i> and ordered by your <i>PCP</i> (<i>ambulance, medi-van</i> or similar medical ground, air or water transport to or from the <i>hospital</i> or both ways). Transfer from a <i>hospital</i> to a lower level of care is covered only when <i>medically necessary</i> and <i>authorized</i> by your <i>physician</i> . The <i>medically necessary ambulance</i> transport <i>coinsurance</i> applies to each transport. <i>Coinsurance</i> waived if transferred from one acute <i>inpatient</i> facility to another.		20% <i>coinsurance</i> per transport (<i>Coinsurance</i> is waived if transferred from one acute <i>inpatient</i> facility to another)

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Behavioral Health		
All Behavioral health services require an <i>authorization</i> from your assigned <i>behavioral health network</i> . You may access those services directly by calling the Mental Health telephone number listed on your <i>ID card</i> . When you call this number, identify <i>yourself</i> as an <i>ADVANTAGE member</i> and you will be assisted. You will be asked for specific information in order to provide you with <i>authorization</i> to the appropriate behavioral health services and <i>participating providers</i> .		

DESCRIPTION OF COVERED SERVICES

COPAYMENT

COINSURANCE

ADVANTAGE ensures you can obtain behavioral health services in a timely manner. The ADVANTAGE appointment standards for behavioral health care are:

- Routine office visits within 10 business days
- Initial non-urgent appointments within 10 business days
- Urgent appointments within 24 hours
- *Emergency Care* is immediate

Mental Health Services Option:

- *Inpatient psychiatric hospital* services, including evaluation and treatment in a psychiatric day treatment facility, when *medically necessary*, ordered by your designated behavioral health provider for mental health services and authorized by the behavioral health network. Limited to 2 copayments per calendar year. \$250 copayment
- *Outpatient visits* will be provided when *medically necessary* and ordered by your designated behavioral health provider. Copayment applies to both individual therapy and Group therapy sessions. \$35 copayment
- *Partial hospitalizations* \$125 copayment
Two (2) days of *partial hospitalization* count as one (1) day of *inpatient* services.

Substance Abuse Option:

Covered services are provided without limits when treatment of substance abuse and chemical dependency services are required in the treatment of mental illness.

Detoxification for alcohol or other drug addiction is covered on an *inpatient* and/or *outpatient* basis, whichever is determined to be *medically necessary*. To be covered, services must be authorized by your designated behavioral health network. Covered services are subject to the limitations listed below:

- The treatment setting, e.g., *inpatient*, *outpatient*, residential or transitional, for the treatment of alcohol or other drug dependency shall be determined by your behavioral health network designated by ADVANTAGE in accordance with *medical necessity*.
- The number of rehabilitation days covered represents the days per Contract year of *inpatient* or intensive *outpatient* daycare. Depending on the level of care *medically necessary* for the treatment of alcohol or other drug dependency, covered *inpatient* days will be counted against the rehabilitation day limitations as follows:
 - One (1) *inpatient* day = one (1) residential day
 - One (1) extended day *outpatient* treatment = one half *inpatient* day
- Uniformed *Inpatient* Substance Abuse Services: \$250 copayment
Limited to 30 days per calendar year. Additional 30 days available at 50% coinsurance.
Lifetime maximum of 2 detoxification admissions.
- Non-Uniformed *Inpatient* Substance Abuse Services: \$250 copayment
Limited to 14 days per calendar year. Lifetime maximum of 2 detoxification admissions.
- *Outpatient* Substance Abuse Services: 50% coinsurance
Limited to 20 visits per calendar year.
- *Partial hospitalizations*: \$125 copayment
Two (2) days of *partial hospitalization* count as one (1) day of *inpatient* services.

Pervasive Development Disorder

Pervasive Developmental Disorder means a neurological condition, including, but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Coverage for services will be provided as prescribed by the insured's treating physician in accordance with a treatment plan. Any exclusion within the policy, Certificate, or Contract that is inconsistent with the treatment plan does not apply. The benefits for pervasive developmental disorder will not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to physical illness generally under the accident and sickness insurance Contract.

Included in physician office visit copayment

Corrective Appliances and Prosthetics

Corrective appliances and prosthetics must be medically necessary and used to restore function or to replace body parts. They must be provided with a proper referral and as prescribed by the participating physician.

Examples of corrective appliances include, but are not limited to

- Pacemakers
- Hemodialysis equipment
- Breast prostheses
- Prosthetic limbs
- Back braces
- One pair of eyeglass lenses following cataract surgery not to include tinting, scratch-proofing or transitioning.
- Ostomy supplies

Covered services include the purchase, replacement or adjustment of artificial limbs or eyes, when required due to a change in your physical condition or body size due to normal growth.

50% coinsurance

What are the non-covered services or limitations?

- Appliances and aids which are not necessary for the restoration, function or replacement of a body part.
- Non-durable appliances.
- Hearing aids.
- Dental appliances.
- Dentures.
- Foot Orthotics

Please refer to Section 5, Other Non-covered services and Limitations on Benefits for additional explanation of the specific services not covered under this Certificate.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
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Dental – Limited Covered services

Medical services related to *injury* to sound and natural teeth when *injury* is reported immediately, and treatment must be sought with proper referral to a *participating provider* within a 72-hour period. *Injury* must be traumatic (an *injury* to living tissue caused by an extrinsic agent) or caused by the force of an external object striking the tooth. After *emergency* treatment, follow-up care must be obtained from a *participating provider* upon a *proper referral* from the *PCP* and initiated within sixty (60) days of the *injury*. All treatment must be completed within one year from the initiation of treatment and accident must have been incurred on or after the *effective date of coverage*

\$35 *copayment*

Hospital and anesthesia services related to dental care are covered if:

- *You* are under age 19, or *you* are 19 or older and have a record of, or are regarded as having, a physical or mental impairment that substantially limits one or more of *your* major life activities; and
- *Your* mental or physical condition requires that dental care be provided in a *hospital* or *outpatient* surgical center.

The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the standards for determining whether performing dental procedures necessary to treat the individual’s condition under general anesthesia constitutes appropriate treatment.

The dental procedure is excluded from *covered services*. The “*Inpatient Hospital Services*” *copayment* or *coinsurance* will apply to *inpatient* services. The “*Outpatient Surgical Services*” *copayment* or *coinsurance* will apply for *outpatient* services in a *provider network hospital* or *provider network outpatient* facility.

What are the other non-covered services or limitations?

- Injured teeth must be sound and natural, including teeth that have been filled, capped, or crowned
- Accident must have been incurred on or after the *effective date of coverage* with *ADVANTAGE*
- All unauthorized services, or services rendered by a non-*participating provider* are *non-covered services*
- All services not completed within one year from initiation of treatment are *non-covered services*
- Repair of *injury* caused by an intrinsic force, such as the force of the upper and lower jaw in chewing, are *non-covered services*
- Repair of artificial teeth, dentures or bridges are *non-covered services*

Please refer to Section 5, Other Non-covered services and Limitations on Benefits for additional explanation of the specific services not covered under this Certificate.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
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Diabetes Self Management Training

Covered services are limited to

- *Physician* authorized visit(s) after receiving a diagnosis of diabetes
- *Physician* authorized visit(s) after receiving a diagnosis that represents a significant change in *your* symptoms or condition and there is a *medically necessary* change in *your* self-management
- *Physician* authorized visit(s) for re-education or refresher training

Diabetes self-management training

No *copayment*

No *coinsurance*

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Dialysis <i>Outpatient or inpatient dialysis services with a proper referral and provided by a participating provider.</i>	\$0 copayment	

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Durable medical equipment (DME) Rental or purchase of <i>DME</i> , including all durable and non-durable supplies required to operate the <i>DME</i> and are integral to the <i>DME</i> set-up. The following <i>covered services</i> apply if there is a <i>proper referral and</i> : <ul style="list-style-type: none"> • When <i>medically necessary</i> • When equipment can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of <i>illness</i> or <i>injury</i> and is suitable for use in <i>your</i> home. Examples of <i>DME</i> include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, <i>hospital</i> beds, monitoring devices, oxygen-breathing apparatus, and insulin pumps. • Training in the use of any <i>medically necessary</i> covered <i>DME</i> is also covered, when so authorized • Rental payments apply to purchase of equipment 		50% coinsurance

What are the non-covered services or limitations?

- Equipment that cannot withstand repeated use.
- Equipment that is not medical or not primarily and customarily used to serve a medical purpose; equipment that serves as useful in the absence of *illness* or *injury*.
- Equipment that is not suitable for use in the home.
- *You* are entitled only to the basic type of *DME* necessary to provide for *your* medical needs as determined by *your physician* and authorized by *ADVANTAGE*.
- Items and equipment specifically fitted to an individual and not appropriate for repeated use by multiple patients.

Examples of non-covered items: corrective shoes; arch supports; hearing aids; dental prostheses; deluxe equipment; common first aid supplies; and non-durable supplies which are not required to operate a durable medical device and are not an integral part of the *DME* set-up.

Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this Certificate

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Emergency services and Urgent care An <i>emergency service</i> means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to: <ul style="list-style-type: none"> • place an individual's health in serious jeopardy; • result in serious impairment to the individual's bodily functions; • or result in serious dysfunction of a bodily organ or part of the individual. Examples include, but are not limited to, heart attacks, strokes, poisonings, severe bleeding and convulsions. Emergency Room: Includes all related services <i>Copayment</i> waived if admitted	\$125 copayment	

What should I do first?

If you feel you have a medical emergency, and if there is time, you are encouraged to call your PCP for advice and instructions. Your PCP may direct you to a hospital emergency room or urgent care center, or your PCP may be able to see you in the office. If a medical emergency is so serious that in the absence of immediate medical attention it could be life-threatening or cause serious disability or significant jeopardy to your health, go immediately to an emergency facility or call 911.

What do I do if I need follow-up care?

If you receive emergency services or urgent care services, you should contact your participating provider’s office within 48 hours or as soon as reasonably possible after you receive the services to allow your PCP to arrange follow up treatment.

Notice to the PCP allows the PCP to be informed of your condition and, once you are stabilized, to coordinate your care. In the case of a non-participating hospital, contact ADVANTAGE as soon as possible. ADVANTAGE and your attending physician may direct your transfer to a hospital in the provider network once your health condition has been stabilized.

To “stabilize” means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of the individual’s condition is not likely to result from or during any of the following:

- The discharge of the individual from an emergency department or other care setting where emergency services are provided to the individual;
- The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility;
- The transfer of the individual from a hospital emergency department or other hospital care setting where emergency services are provided to the individual to the hospital’s inpatient setting.

What if I need emergency services while I am outside the service area?

If you become ill or injured while you are temporarily away from the service area, ADVANTAGE will cover care for emergency services and urgent care. If you are hospitalized outside of the service area, contact ADVANTAGE as soon as you are able. If you have any questions about how to obtain medical services when you are out-of-area, please call the ADVANTAGE Member Services phone number listed on the back of your ID card. If there is time, you should try to call your PCP for advice and instructions.

Always remember. . .

- You are encouraged to call your PCP to arrange for emergency care if there is time.
- Be sure to contact your participating provider within forty-eight (48) hours after receiving emergency care.
- If you use the emergency room or urgent care for non-emergency care that is not properly referred and authorized, you will be responsible for the entire cost.
- If you are admitted following emergency care, you must contact ADVANTAGE or your PCP (or someone may contact your PCP on your behalf) **within forty-eight (48) hours** of admission or when you are medically able to do so. If the member is a minor, the parent or guardian must contact the PCP. If you are admitted to the hospital directly from the emergency room, your copayment is waived for the emergency service.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
<i>Urgent care</i> : includes related services and after hours and physician home visits.		
• In-area	\$50 copayment	
• Out-of-area	\$50 copayment	

Remember, urgent care is determined by medical condition, not the place of service. Urgently needed services or urgent care services are instances when you need covered services urgently:

- to prevent serious deterioration of health;
- resulting from an unforeseen illness or injury;
- while outside of the service area; or
- for which treatment cannot be delayed until you return to the service area without your condition growing much worse.

If you have an *urgent* medical problem that is not an *emergency*, but needs timely attention, simply call your *PCP's* office, even if you are out of the *service area*. Your *PCP* knows your medical history and will be in the best position to evaluate your needs. You may be directed by your *PCP* to an *urgent care* center or *emergency* room. Please follow your *PCP's* instructions to ensure services are covered.

An *urgent care* center is a medical facility, where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive *urgent care services*. Coverage for *urgent care* includes after hours and *physician* home visits.

As explained in this Section, if you receive *emergency services* or *urgent care services*, you must contact ADVANTAGE or your *PCP's* office within 48 hours or as soon as reasonably possible after you receive the services.

- **Full time students are covered for *emergency services* or *urgent care* while they are outside the *service area*. However, all follow-up care and care that is not considered *emergency services* or *urgent care* under this *Certificate* must be properly referred and authorized by the student's *PCP* to receive covered benefits.**

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Health Education		
Health education provided by the <i>PCP</i> as part of preventive health care and other health education classes approved by <i>ADVANTAGE</i> . Classes in nutrition or smoking cessation will be approved up to three (3) visits when referred by your <i>physician</i> .	No <i>copayment</i> applies to health education provided by the <i>PCP</i> as part of preventive health care.	

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Home health services		
<p>Medically necessary home health services with a proper referral, including:</p> <ul style="list-style-type: none"> • Skilled medical services. If continuous medical or skilled nursing services are required, <i>ADVANTAGE</i> may require transfer to a <i>SNF</i> or other facility if medically appropriate and more cost effective. • Nursing care given or supervised by a <i>Registered nurse (RN)</i>. • Nutritional counseling furnished or supervised by a registered dietician. • Home hospice services. • Home health aides • Medical supplies, laboratory services, drugs, and medicines prescribed by a <i>physician</i> in connection with home health care. • Medical social services. • Training of family members or significant other to provide those <i>home health services</i> that can be performed by laypersons. 	\$0 <i>copayment</i>	
<p>Services are considered <i>covered services</i> only if they are not considered <i>custodial care</i> and the services are prescribed in writing by a <i>participating physician</i>:</p> <ul style="list-style-type: none"> • As <i>medically necessary</i> for the care and treatment of your <i>illness</i> or <i>injury</i> at home; • As being in place of <i>inpatient hospital</i> care or a convalescent nursing home that would be required in the absence of such services; and • The services are furnished to you while under a <i>participating physician's</i> care. 		

Hospital Care (Inpatient and Outpatient Medical and Surgical)*Inpatient Hospital Services:*

Inpatient biologic/biopharmaceutical medications do not require additional *copayment* or *coinsurance*. Copayment limited to 2 inpatient admissions per calendar year.

\$250 *copayment* per *admission* after deductible (waived if re-admitted within 24 hours of discharge)

Outpatient Surgical Services:

Outpatient surgery facility services including those diagnostic invasive procedures that may or may not require anesthesia.

\$125 *copayment* after deductible

What do I do when I need to be hospitalized?

Your physician will arrange your admission to a hospital in the provider network.

How do I select a hospital or outpatient facility?

- When you select a PCP, you agree to utilize the hospitals and facilities in your PCP's provider network.

What are the covered services?

The *inpatient* and *outpatient* medical and surgical hospital services are covered when *medically necessary* and *prior authorized*, by ADVANTAGE.

- *Inpatient* medical and surgical services;
- Semi-private room and board (Private room provided when *medically necessary*);
- Intensive Care Unit/Coronary Care Unit;
- *Inpatient* cardiac rehabilitation, limited to annual maximum of 90-days;
- *Inpatient* rehabilitation therapy which includes physical, occupational, speech and pulmonary of acute *illness* or *injury* to the extent that significant potential exists for progress toward a previous level of functioning limited to an annual maximum of 90 days.
- *Outpatient* medical and surgical services, including those diagnostic invasive procedures, which may or may not require anesthesia;
- Other *medically necessary inpatient hospital* services, including but not limited to: general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in *hospital*; laboratory and x-ray examinations; electrocardiograms; and special duty nursing (when requested by a *physician* and certified as *medically necessary*).
- *Inpatient* biologic/biopharmaceutical medications do not require additional *copayment* or *coinsurance*.

Medically necessary professional services for surgical operations (major and minor), include but are not limited to:

- Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident occurring while a *member* (if services begin within one year of the accident);
- Replacement of diseased tissue surgically removed while a *member*;
- Treatment of a birth defect in a Dependent child;

ADVANTAGE is a health maintenance organization responsible for arranging for the provision of *covered services* under your benefits. Federal law requires health carriers that provide medical and surgical benefits for mastectomies to also cover reconstructive surgery and other related services following a mastectomy. Under the law, if a *member* has a mastectomy and, in consultation with the *physician*, elects to have reconstructive surgery, the *covered services* would include:

- Reconstruction of the breast upon which the mastectomy was performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - Prostheses and physical complications at all stages of mastectomy, including lymphedemas.
- The manner of treatment for any given patient is to be decided in consultation with the attending *physician* and patient. The law permits *copayments*, *coinsurance* and *deductibles* to apply.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Infertility diagnostic testing up to diagnosis of infertility only, and infertility counseling:		
For <i>medically necessary</i> treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies for the reproductive system.	\$35 copayment	

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Injections (Therapeutic) and Infusion Therapy		
<i>Outpatient</i> therapeutic injections which are <i>medically necessary</i> and which may not be self-administered. Injections include, but are not limited to chemotherapy, antibiotics, analgesics, hydration, total parenteral nutrition (TPN), Prolastin, and Factor 8 injections, which are <i>medically necessary</i> . Self-injectables are <i>covered services</i> only when authorized by <i>ADVANTAGE</i> . <i>Biopharmaceutical Drugs</i> are subject to the <i>copayment</i> or <i>coinsurance</i> indicated.		
Therapeutic injections and infusions (non- <i>Biopharmaceutical drugs</i> or insulin drugs):	\$0 copayment	

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Maternity Care		
<ul style="list-style-type: none"> Professional obstetrical care, including prenatal visits, antepartum care, and one postpartum visit per pregnancy term regardless of date of conception. Including <i>physician services</i>, laboratory and x-ray services as <i>medically necessary</i> and appropriate. 	One time <i>copayment</i> of: \$20 initial visit (<i>PCP</i>) One time <i>copayment</i> of: \$35 initial visit (<i>SCP</i>)	

Please refer to “Hospital Care” for inpatient benefits

The benefits include *physician services*, *hospital services*, and laboratory and x-ray services as *medically necessary* and appropriate.

After a normal, vaginal delivery, a woman and her newborn child may stay in the *hospital* for a minimum of 48 hours. After a Cesarean section, a woman and her newborn child may stay for a minimum of 96 hours. A shorter length of stay is included in *covered services*, if: the woman and attending *physician* agree that the woman or newborn child does not need further *inpatient* care; in the attending *physician*’s opinion the newborn meets the criteria for medical stability under the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists Guidelines; and an “*at home post delivery care*” visit is provided.

Unplanned interruption of pregnancy (miscarriage) will be treated as any other *illness*, including, but not limited to *medically necessary physician’s services*, *hospitalizations*, x-ray and laboratory services.

Always remember...

You MUST make an election to enroll the newborn within the first 31 days of birth for *coverage* to continue past the 31st day.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
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DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Medical Social Services <i>Hospital</i> services to assist <i>you</i> and <i>your</i> family in understanding and coping with the emotional and social problems affecting health status. There is no <i>copayment</i> for this <i>covered service</i> .	\$0 <i>copayment</i>	

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Medical Supplies Casts, dressings, splints, and other devices used for reduction of fractures and dislocations. There is no <i>copayment</i> for this <i>covered service</i> .	\$0 <i>copayment</i>	

What are the non-covered services?

Non-durable supplies and/or convenience items are not covered.

Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate*.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Morbid Obesity Option <i>Morbid Obesity</i> means: <ul style="list-style-type: none"> • A body mass index of at least thirty-five (35) kilograms per meter squared, with co-morbidity coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or • A body mass index or at least forty (40) kilograms per meter squared without co-morbidity. Non-surgical Treatment for Morbid Obesity As an alternative to surgical treatment for <i>morbid obesity</i> , <i>ADVANTAGE</i> will pay for enrollment in an in-network <i>physician-supervised</i> weight loss treatment program when referred by your physician and authorized by <i>ADVANTAGE</i> .		Enrollment fees in excess of \$50 after \$35 <i>copayment</i> per visit. Maximum of 6 visits per <i>calendar</i> year.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Newborn Examinations Newborn examinations are covered under maternity care, or <i>hospital</i> care, or <i>physician</i> office visits. Newborn examinations include the detection of: <ul style="list-style-type: none"> • <i>Inherited Metabolic Disease</i> includes services for <i>medical food</i> and <i>low protein modified food products</i>, (not subject to <i>copayment</i>, regardless of supplier) as defined in the Glossary of Terms. • Hypothyroidism • Hemoglobin paths, including sickle cell anemia • Galactosemia • Maple Syrup Urine Disease 	No additional <i>copayment</i>	

- Homocystinuria
- Inborn errors of metabolism that result in mental retardation and that are designated by the State Health Department
- Physiologic hearing screening examinations for detection of hearing impairments

If a parent of an infant objects in writing, for reasons pertaining to religious beliefs only, the infant is exempt from the examinations.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Outpatient Services		
Outpatient Services including but not limited to: laboratory, pathology, radiology ; Services in PCP or SCP office	Included in office visit <i>copayment</i>	
Services in other <i>outpatient</i> setting	\$0 <i>copayment after deductible</i>	
Electrocardiology (EKG) and electroencephalography (EEG), MRI, CT, MRA, SPECT and PET scan	\$0 <i>copayment</i>	
	\$50 <i>copayment after deductible</i>	

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Physician Services – Office visits for the treatment of illness or injury		
Office Visit Services:		
• Primary care physician Office Visit	\$20 <i>copayment</i> per office visit	
• Specialty and Referral Physician Office Visit	\$35 <i>copayment</i> per office visit	
• Office visits, services and supplies for the determination and/or treatment of <i>illness or injury</i> . These services include medical consultations, and procedures performed in the <i>physician's</i> office, <i>second opinion</i> consultations, and specialist treatment services.		
• Allergy Testing		
• Diabetes self-management training		
• Maternity care – refer to Maternity Care benefit		

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Physician Services – Non-Office Visit Services		
• Primary care physician, Specialty and Referral for all Physician Services in the Hospital or Outpatient Facility	\$0 <i>copayment</i>	
• Primary care physician, Specialty and Referral Physician visits in the Home when provided by your participating physician	\$50 <i>copayment</i>	

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
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Physician Services for wellness and preventive services

The following services will be included in the office visit *copayment* when services are performed in the *physician* office. Services performed outside of the *physician* office will not have a *copayment*.

Included in the
physician office visit
copayment

Provided by the *PCP* or other authorized *provider* including, but not limited to:

- Routine physical exam – Periodic health appraisal examinations for *members* who are less than 18 years of age for the prevention and detection of disease as recommended by the American Academy of Pediatrics. For *members* age 18 and older, history and periodic health evaluations (physical examinations for the prevention and detection of disease) limited to the extent *medically necessary* or appropriate.
- Routine total blood cholesterol screening
- Colorectal Cancer screening – Colorectal cancer examinations and laboratory tests, as mandated by Indiana State Law, must be covered for any non-symptomatic individual in accordance with current American Cancer Society Guidelines for a covered person who is:
 - a) at least fifty (50) years of age; or
 - b) Less than fifty (50) years of age and at high risk for colorectal cancer.

Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.

- Routine gynecological services
- Routine mammographies – Breast cancer screening tests as mandated by Indiana State Law, include;
 - a) One (1) baseline screening mammography before the age of forty (40) for a *member* who is at least thirty-five (35) years old;
 - b) Annual screening mammography if at risk and less than forty (40);
 - c) Annual screening mammography for *members* forty (40) years old and older;
 - d) Any additional mammogram views needed for proper evaluation and ultrasound services; if *medically necessary*.

Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.

- Routine Prostate Specific Antigen (PSA) Test as mandated by Indiana State Law, include;
 - a) At least one (1) PSA test annually for an individual who is at least fifty (50) years old;
 - b) At least one (1) PSA test annually for an individual less than fifty (50) who is at high risk of prostate cancer according to the American Cancer guidelines.

Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.

- Routine immunizations- Immunizations and inoculations (vaccine and administration of vaccine) based on the guidelines of the Advisory Committee on Immunization Practices (ACIP) or at *ADVANTAGE*'s discretion, other nationally recognized organizations, such as the American Academy of Pediatrics (AAP) or the Academy of Family *Physicians* (AAFP).
- Hearing tests – Hearing examinations, as mandated by Indiana State Law, including an infant physiological hearing screening examination at the earliest feasible time for the detection of hearing impairments.
- Vision screening

PHARMACY SERVICES**Outpatient Prescription Drug Option**

All *covered services* for *outpatient* prescription drugs will be subject to inclusion on the *formulary* and a mandatory generic requirement. This means when the *member* or *physician* chooses a *brand-name drug* instead of the available *generic*, the *member* must pay the higher *copayment* or *coinsurance* plus the cost difference between the *brand* and the *generic*. You must satisfy the outpatient prescription drug *deductible*.

All prescriptions must be prescribed by a *participating provider* in order to receive this *covered service*. *ADVANTAGE* requires that all prescriptions be filled with the most cost-effective *generic* medication, if available, and approved by the Food and Drug Administration (FDA) for the prescribed indication, dosage and administration, and subject to the limitations and exclusions described in this Section. *Covered services* include: all drugs requiring a prescription either by State or Federal law, except injectables (other than insulin); All compound prescriptions that contain at least one covered prescription ingredient; and insulin and insulin needles and syringes, when prescribed by a *participating*

physician and dispensed to you. The quantity dispensed shall be limited to that sufficient to treat acute phase of illness or a thirty-(30) day supply, whichever is less, per copayment or coinsurance.

Please refer to the cover page of this Certificate to determine if you have any deductible or Out-of-pocket Maximum applicable to your prescription covered services.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
<p>Outpatient Prescription Drug THREE TIER Option INCLUDES: DIABETES SUPPLIES (Please refer to the formulary)</p>		
<p><u>TIER 1 - Preferred Generic drug</u> When you receive a Preferred Generic drug, you pay the lowest out-of-pocket cost for the prescription.</p>	<p>Retail: \$10 copayment per prescription up to a 30-day supply Mail Order: \$20 copayment per prescription up to a 90-day supply</p>	
<p><u>Tier 2 – Non-Preferred Generic Drug</u></p>	<p>Retail: \$20 copayment per prescription up to a 30-day supply Mail Order: \$40 copayment per prescription up to a 90-day supply</p>	
<p><u>TIER 3 - Preferred Brand-name drug</u> If you or your physician requests a brand-name drug when there is a generic equivalent available, you will be charged the Preferred Brand-name drug copayment PLUS the difference between ADVANTAGE’s maximum allowable charge for the generic and the brand-name contract price.</p>	<p>Retail: \$30 copayment per prescription up to a 30-day supply Mail Order: \$60 copayment per prescription up to a 90-day supply</p>	
<p><u>TIER 4 -Non-Preferred Brand-name drug</u> If you or your physician requests a non-formulary brand-name drug when there is a generic equivalent available, you will be charged the Non-Preferred Brand-name drug copayment PLUS the difference between ADVANTAGE’s maximum allowable charge for the generic and the Non-Preferred Brand-name drug contract price.</p>		<p>Retail: 50% coinsurance per prescription up to a 30-day supply Mail Order: 50% coinsurance per prescription up to a 90 day supply.</p>

What is a *formulary*?

ADVANTAGE utilizes a prescription drug *formulary*. A *formulary* is a list of preferred *generic* and *brand name* prescription medications that have been approved by the Food and Drug Administration (FDA). Each “Tier” is described in the *formulary* document, and you may review the most-recent *formulary* by logging onto www.advantageplan.com.

ADVANTAGE has a team of *physicians* and pharmacists who meet regularly throughout the year to review and update the *formulary*. It includes medications for most conditions treated outside the *hospital*. Your *participating physician* will refer to the *formulary* to select medications that are appropriate to meet your healthcare needs, while helping you maximize your prescription drug benefit. *Participating physicians* and pharmacists are provided with information about ADVANTAGE’s *formulary* and updates as new medications are approved to be added to the *formulary* or when current medications are replaced.

What is a *generic drug*?

A *generic drug* is a copy of a *brand name* drug for which the patent has expired. The *generic drug* may be of different shape, size, color or flavor, but the active, therapeutic agents are the same as the *brand name* drug. The same quality and safety standards that apply to *brand name* drugs also apply to the *generic* form. The FDA sets standards and reviews all *generic* medications before marketed.

What is a *brand-name drug*?

A *brand name* drug is a drug that has been manufactured under a patent and in accordance with the approval for the FDA.

Is prior authorization required for *outpatient* prescription drugs?

A limited number of prescription drugs require prior *authorization*. The pharmacist will advise you if your prescription requires prior *authorization*. Your prescribing *physician* is required to complete a “Letter of Medical Necessity” and fax it to the pharmacy benefits manager’s *authorization* unit. The information is reviewed for clinical information that would indicate the prescription drug is covered under your benefit plan for your circumstances. *Participating physicians* have been educated about the prior *authorization* drug process. Many *physicians* will complete the “Letter of Medical Necessity” at the time he/she provides you with the prescription.

If the prescription is *authorized* after review, a Member Services Representative will notify you as quickly as possible. If *authorization* is denied, a clinical specialist will notify the prescribing *physician* to discuss the clinical guidelines used for the denial, and you will be notified of the denial in writing and of your right to appeal.

If you have questions about the prior *authorization* process for prescription drugs, please contact a Member Services Representative for assistance.

What are the *non-covered services* or limitations?**LIMITATIONS**

You will be reimbursed, less the applicable *copayment*, *coinsurance* and *deductible*, if applicable for prescription drugs obtained from other than the designated ADVANTAGE *participating pharmacies*, only when the drug was:

- Ordered in connection with an out-of-area *emergency* covered under the *emergency services* section described in this *Certificate* ;
- Ordered by a *physician* for immediate use because of *medical necessity* and because your designated pharmacy is not open for business at that time.

Reimbursement in the above two circumstances will be limited to the *Maximum allowable amount* of cost for a quantity of the drug sufficient to treat the acute phase of the *illness* or to a maximum of thirty (30) day supply, whichever is less.

A drug not approved by the FDA may be prescribed if one of the following conditions is met:

- the drug is recognized for treatment of the indication in at least one (1) standard referenced compendium; or
- the drug is recommended for that particular type of cancer and found safe and effective in informal clinical studies; the results which are published in the United States or Great Britain.

Covered services will only be provided in the quantity equal to the amount prescribed for use through the last day of eligibility.

NON-COVERED SERVICES

- Injectables, which are not listed on the *formulary*;
- Implantable drugs; implantable devices for the administration of drugs;

- Devices and appliances other than insulin syringes/needles (e.g., diaphragms, cervical caps or intrauterine devices (IUDs);
- Drugs administered in *physician's* offices, *hospitals*, nursing homes, *ADVANTAGE* Skilled Nursing Facilities and hospices;
- Except for Nicotine Patches obtained through a prescription, all over the counter (OTC) drugs;
- Drugs whose purpose is the treatment of infertility or impotence; except for drugs approved through the *ADVANTAGE* review process, drugs prescribed that are investigative or *experimental* in nature. A drug shall be considered *experimental* if it has not been approved by the FDA and if the FDA has not approved the drug for the route of administration, the dosage involved, or except as otherwise required by law for certain cancer drugs, the specific indications for which the drug is being prescribed;
- Drugs used for *cosmetic* or recreational purposes (e.g., anabolic steroids, anorexiant, topical minoxidil, or Retin-A for wrinkles, however, retonic acid creams are covered when used in connection with the treatment of severe acne.) Drugs prescribed as part of the treatment for congenital defects or anomalies, shall not be considered *cosmetic* for purposes of this Section;
- Anorexiant, food supplements and other drugs when prescribed for the treatment of obesity;
- *Hospital* discharge drugs; take-home drugs;
- Oral prescription medications when prescribed for foreign travel;
- Replacement of drugs due to loss, theft or negligence;
- Maintenance drugs when filled at a Non-*ADVANTAGE participating pharmacy*;
- Excluded prescriptions may be purchased at a participating *ADVANTAGE participating pharmacy* at *ADVANTAGE's* negotiated discount price.
- Growth Hormones and related products
- Vitamins and Nutritional Supplements

Where do I get my prescriptions filled?

Retail Pharmacy Locations

ADVANTAGE contracts with Pharmacy Benefit Manager to provide retail prescriptions at the following store pharmacies

- CVS
- Meijer
- Wal-Mart
- Kroger
- Kmart
- Walgreens
- Target
- Marsh

Other local and regional pharmacies may participate in our pharmacy network. *You* can find a complete listing of pharmacies that participate with our network and *ADVANTAGE* by calling 800-553-8933. All prescriptions must be filled through Pharmacy Benefit Manager, or *you* may save money by having *your* refillable prescriptions provided through the Pharmacy Benefit Manager mail order program (see below for more information).

Mail Order Program

Under the Prescription Drug Program, *you* may receive covered maintenance prescriptions through the Pharmacy Benefit Manager approved mail order program. Maintenance prescriptions are those that eligible *members* may receive a savings for up to a maximum 90-day supply per prescription.

You may begin using the mail order prescription program by completing the Mail Order Form provided with *your* new *member* welcome packet (contact an *ADVANTAGE* Member Services Representative if *you* need a Mail Order Form). *You* must call *your physician's* office and request a new prescription for the maximum days supply allowed. Mail *your* new prescription(s) and *your copayment(s)* or *coinsurance* along with the completed form in the envelope attached to the order form. Please allow for an average delivery time of two weeks.

If *you* have questions about the prescription drug benefits, please contact an *ADVANTAGE* Member Services representative for assistance.

Always remember...

Keep *your PCP* informed of medications prescribed by specialty care *providers* or behavioral health *providers* to prevent adverse drug interactions.

Biopharmaceutical Drugs	<i>COPAYMENT</i>	<i>COINSURANCE</i>
<i>Biopharmaceutical drugs</i> means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. <i>Biological</i> or <i>biopharmaceutical products</i> typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct <i>physician</i> involvement, and significant <i>member</i> education. These services must be <i>authorized</i> by <i>ADVANTAGE</i> . <i>Coinsurance</i> applies to drugs dispensed up to a 30 day supply.	\$125 <i>copayment</i> /30-day supply applies PLUS applicable office visit <i>copayment</i>	

<i>DESCRIPTION OF COVERED SERVICES</i>	<i>COPAYMENT</i>	<i>COINSURANCE</i>
<i>Skilled nursing facility/hospice facility:</i> Limited to 100 days per “ <i>Benefit period</i> ” as defined by Medicare and in this <i>Certificate</i> . Day limits do not apply to hospice. <i>Skilled nursing facility (SNF)/Extended Care Services, inpatient hospice:</i> <i>Covered services</i> when <i>medically necessary</i> with a <i>proper referral</i> include: <ul style="list-style-type: none">• Semi-private room; private room provided when <i>medically necessary</i>.• Drugs, biologicals, medical social services, short term physical, speech, occupational therapies (subject to limitations listed in the Short-term Therapies indicated below) and other services generally provided by <i>skilled nursing facilities</i>.• <i>Hospice care</i> provided if <i>you</i> are <i>terminally ill</i>, in accordance with a treatment plan developed before <i>your</i> admission to the <i>hospice care</i> program. Treatment plan must include a statement from the <i>physician</i> documenting that life expectancy is six months or less.	\$0 <i>copayment</i>	

<i>DESCRIPTION OF COVERED SERVICES</i>	<i>COPAYMENT</i>	<i>COINSURANCE</i>
<i>Therapies -- Short-Term:</i> Short-Term Therapies are limited to a combined 60 visits per each distinct condition or episode, or as authorized through a medical management regimen <u>Short-term Physical Therapy</u> Short-term physical therapy – covered with <i>prior authorization</i> for a condition that the <i>physician</i> believes is subject to continuing improvement. <u>Short-term Speech and Occupational Therapy</u> Short-term speech or occupational therapy – services are covered with <i>prior authorization</i> , if provided to correct an impairment due to <i>injury</i> or <i>illness</i> ; or a congenital defect.	\$35 <i>copayment</i>	

Covered services for speech therapy when provided to restore speech after a loss or impairment of a previous, demonstrated ability to speak; or develop or improve speech after surgery to correct a defect that existed at birth and impaired, or would have impaired, the ability to speak. ***Covered services do not include speech therapy due to a delay in speech development.***

Short-term Cardiac Rehabilitation

Short-term services that may be *medically necessary* for the improvement of cardiac disease or dysfunction.

Short-term Pulmonary Rehabilitation

Short term services that may be *medically necessary* for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent *emergency* room visits, progressive dyspnea, hypoxemia, or hypercapnia.

DESCRIPTION OF COVERED SERVICES	COPAYMENT	COINSURANCE
Transplant Services		
<p><u>Transplants:</u> Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a <i>member</i>; Includes a maximum lifetime limit of \$10,000 for <i>covered services</i> related to transportation and lodging for the donor. The maximum lifetime limit for <i>covered services</i> related to transportation and lodging applies to the <i>policy maximum</i>. No <i>coverage</i> is provided for the donor or the recipient when the recipient is not a <i>member</i>. The <i>inpatient</i> medical <i>copayment/coinsurance</i> applies as specified. The <i>SCP</i> office visit <i>copayment/coinsurance</i> applies as specified for pre-transplant evaluation.</p> <p>Non-<i>experimental</i>, non-<i>investigational</i> organ and other transplants are covered.</p> <p><i>ADVANTAGE</i> will cover the donor’s medical expenses if the person receiving the transplant is an <i>ADVANTAGE member</i> and the donor’s expenses are not covered by another health benefit <i>carrier</i>.</p>	<p>Applicable inpatient/outpatient <i>copayment/coinsurance</i> will apply and, in addition any applicable office visit <i>copayment/coinsurance</i> applies for pre-transplant evaluation</p>	<p>Applicable inpatient/outpatient <i>copayment/coinsurance</i> will apply and, in addition any applicable office visit <i>copayment/coinsurance</i> applies for pre-transplant evaluation</p>

SECTION 5: OTHER NON-COVERED SERVICES AND LIMITATIONS ON BENEFITS

The following section indicates the items which are not *covered services* under this *Certificate* and are thus *your* financial responsibility. This information is provided as an aid to identify certain common items which may be misconstrued as *covered services*, but is in no way a limitation upon, or a complete listing of, such items considered not to be *covered services*.

1. Services and supplies that are not performed, arranged, *authorized*, or approved in advance, except as specifically stated in this *Certificate* and/or Member Reference Guide
2. Services and supplies that are not *medically necessary*;
3. Services and supplies that are not specifically listed as *covered services*;
4. Services not within the scope of the *provider’s* license;
5. Services of a provider who is a member of the patient’s immediate family or who normally resides in the patient’s household.
6. Services and supplies provided by *your* family, i.e., parent, brother, sister, or child, or someone who lives with *you*;

7. Services of a provider treating himself or herself.
8. Services and supplies that are furnished by a government plan, *hospital*, or institution, unless *you* are legally required to pay for the service;
9. Services and supplies provided prior to *your effective date of coverage* or after *your coverage* is terminated;
10. Services and supplies incurred after *you* leave a program of *inpatient* care for the same condition, against the medical advice of *your physician*;
11. Services and supplies that would have been provided at no cost if *you* did not have *coverage* under *ADVANTAGE*;
12. Services and supplies which are covered, or would have been covered, under any worker's compensation or occupational disease act or law;
13. Except when required by law, services and supplies provided to treat an *illness* or *injury* caused by:
 - any act of declared war;
 - service in the military forces of any country, including non-military units supporting such forces;
 - the commission or attempt to commit a civil or criminal battery or felony; or
 - taking part in a riot ("taking part in a riot" means the use or threat to use, force or violence without authority of law, by four or more persons).
14. All treatments, procedures, facilities, equipment, drugs, devices, services, or supplies that are considered *experimental*;
15. *Cosmetic* or reconstructive procedures, and any related services or supplies, which alter appearance, but do not restore or improve impaired physical function (except for services covered in accordance with the Women's Health and Cancer Act of 1998 and services covered for newborns as outlined in Indiana Code 27-8-5.6-2;); wigs;
16. Services and supplies provided to treat hair loss, promote hair growth, or remove hair. However, *you* are entitled to access *ADVANTAGE's* discount for such drugs through a *participating pharmacy*;
17. Orthognathic Surgery
18. Services and supplies related to narcotic maintenance treatment for opiate addiction;
19. Storage of blood products when not *medically necessary* or not provided in conjunction with a scheduled covered surgery; blood products when replaced by donation;
20. Items or devices primarily used for comfort, including, but not limited to air purifiers, humidifiers, dehumidifiers, whirlpools, air conditioning, waterbeds, exercise equipment, and ultraviolet lighting;
21. Non-skilled care, rest cures, respite care, or domiciliary care, regardless of the setting;
22. Services and supplies provided by *your* family, i.e., parent, brother, sister, or child, or someone who lives with *you*;
23. Private duty nursing services provided for the convenience of *you* or the convenience of *your* family (for example, bathing, feeding, exercising, moving the patient, giving oral medication or acting as a companion or sitter);
24. Room and board services while *you* are permitted to temporarily leave a *hospital*, *SNF*, or *hospice facility*;
25. Orthodontia and other dental services, except as expressly provided for in this *Certificate* or any attachment to this *Certificate* ;
26. All unauthorized dental services, or services rendered by a non-*participating provider*; dental appliances; dentures; dental prostheses;
27. All dental services not completed within one year from initiation of covered treatment;
28. Repair of dental *injury* caused by an intrinsic force, such as the force of the upper and lower jaw in chewing;
29. Repair of artificial teeth, dentures, or bridges;
30. Physical exams and related x-ray and lab expenses, when provided for employment, school, sports' programs, travel, immigration, administrative purposes, or insurance purposes;

31. Pre-marital tests or exams;
32. Other services and/or supplies which are not, in the judgment of *your participating physician, medically necessary* for the maintenance or improvement of *your* health;
33. Services and supplies for the treatment of: adult hyperkinetic syndrome, learning disabilities, mental retardation, behavioral disorders, developmental delay or disorder, or senile deterioration, beyond the period necessary to diagnose the condition.
34. Marriage counseling, personal growth therapy, or sex counseling or therapy;
35. Hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders by the American Psychiatric Association;
36. Self-help training and other related forms of non-medical self care, which are unrelated to mental health;
37. Services and supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction
38. Immunizations provided for the purpose of travel;
39. Supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions, and calluses.
40. Routine foot care except when *medically necessary* for the treatment of diabetes and lower extremity circulatory diseases.
41. Telephone consultants, charges for completion of claim forms;
42. Fees that the *provider* may charge *you* if *you* miss scheduled appointments without canceling with reasonable notice;
43. Chiropractic services;
44. Court-ordered services, unless appropriate, *medically necessary*, and *authorized* by your *physician*;
45. Travel or *hospitalization* for environmental change, or *physician* services connected with prescribing environmental changes;
46. Naturopathic medicine or Christian Science medicine;
47. Acupuncture, except where administered by a *participating provider* and used as an anesthetic agent for covered surgery;
48. Preparation of special medical records or court-ordered appearances for hearing or proceedings;
49. Medical care provided outside the U.S., unless an *emergency*;
50. Massage Therapy
51. Except for *physician*-supervised programs referred by *your physician* and authorized by *ADVANTAGE*, services, drugs, and supplies for weight loss, diet, health or exercise programs, health clubs dues, or weight reduction clinics. However, *you* are entitled to access *ADVANTAGE's* discount for such drugs through a *participating pharmacy*;
52. Vision examinations, refractions, eyeglasses and contact lenses and their fitting; Eyeglass lenses unless *medically necessary* following cataract surgery; refractive surgery performed to treat myopia or hyperopia;
53. Contact Lenses unless: medically necessary for the treatment of Keratoconus; or medically necessary for intraocular implant of lenses for Aphakia or after cataract surgery;
54. Non-prescription glasses or vision devices; orthoptics or vision therapy including eye exercises and any associated supplemental testing;
55. Services or supplies for, or related to:
 - sex change operations or reversal, except for congenital deficiency;
 - artificial insemination
 - gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or in-vitro or in-vivo fertilization;
 - abortion;

- voluntary sterilization or reversal of sterilization;
 - birth control drugs, supplies, or devices; however, *you* are entitled to access *ADVANTAGE*'s discount for such drugs through a *contracting pharmacy*;
 - use of a surrogate for any reason
56. Hearing aids, Hearing therapy, or cochlear implants and their fitting
 57. Audiometric exams for the purpose of hearing aids.
 58. Treatment of temporomandibular joint (TMJ) disorder;
 59. Extensive long-term neuromuscular rehabilitation, i.e., physical, speech or occupational therapy is excluded. Rehabilitation that the *physician* reasonably believes will require in excess of 60 days per each distinct condition or episode, beginning with the first rehabilitation treatment for that condition, will be considered "long-term" and is not covered. (When *you* undergo a rehabilitative treatment for a specific and distinct condition, that visit constitutes one treatment). *ADVANTAGE* reserves the right to extend *covered services* through a formal medical management regimen.
 60. Personal comfort items, including but not limited to services and supplies not directly related to *your* care, such as guest meals and accommodations, private room (unless *medically necessary*), personal hygiene products, telephone charges, travel expenses (other than approved *ambulance* services as provided in the basic health services), take-home supplies including prescription drugs and similar items;
 61. Service obtained by a *member* from *physicians, hospitals* or other *providers* not associated with *ADVANTAGE*, either within the *service area* or outside the *service area* (except *emergency services* or upon proper referral by a *participating physician*);
 62. Recreational or educational therapy;
 63. Treatment and testing for adolescents and children, which are state mandated services by or of the school system, unless therapy is deemed *medically necessary* by a *participating provider*;
 64. Court ordered therapy, unless appropriate, *medically necessary*, and *authorized by your participating behavioral health provider*;
 65. Vocational therapy, including work hardening programs;
 66. Newborn deliveries performed by a midwife in the home and any charges, including but not limited to supplies and equipment as a result of such deliveries.
 67. Treatment or services related to *pre-existing medical condition* which are incurred during the *pre-existing medical condition exclusion period* as defined in this *Certificate*
 68. Growth Hormones and related products;
 69. Services and supplies for the treatment of alopecia and/or alopecia areata;
 70. Corrective appliances and artificial aids which are not necessary for the restoration, function, or replacement of a body part; non-durable appliances;
 71. Speech therapy due to a delay in speech development;
 72. Common first aid supplies;
 73. *Durable medical equipment* that:
 - cannot withstand repeated use;
 - is not medical or not primarily and customarily used to serve a medical purpose;
 - serves as useful in the absence of *illness* or *injury*;
 - is not suitable for use in the home;
 - specifically fitted to an individual and not appropriate for repeated use by multiple patients;
 - is considered deluxe equipment. *Covered services* are only for the basic type of *DME* necessary to provide for *your* medical needs as determined by *your physician* and authorized by *ADVANTAGE*.

74. Non-durable supplies and/or convenience items which are not required to operate a durable medical device and are not an integral part of the *DME* set-up;
75. Non-durable medical supplies for use outside the *hospital* or *physician* office;
76. Surgical treatment of *morbid obesity*;
77. Maternity services when *member* is acting as a surrogate mother.
78. Treatment or services related to *pre-existing medical conditions* which are incurred during the *pre-existing medical exclusion period* as defined in this *Certificate*.
79. Services and supplies provided after *Policy maximum* has been exceeded by the *member*.
80. Medical care for a *preexisting medical condition* of a *Young Adult* until six (6) months after the effective date of the *Young Adult's* coverage with *ADVANTAGE*. This *preexisting medical condition* limitation period will be reduced by the number of days of *prior creditable coverage* the *Young Adult* has at the time of enrollment. The *preexisting medical condition* limitation does not apply to:
 - (1) a *dependent* who, on the date he or she is otherwise eligible for coverage, is adopted by, or placed for adoption with, the *subscriber*; or
 - (2) a newly born *dependent* Child of the *subscriber*,if the child, as of the last day of the 30 day period beginning with the date of birth or date of adoption or placement for adoption, is covered under *creditable coverage*.

Other Limitations

Cost Effectiveness:

ADVANTAGE will not pay the cost of any *inpatient* or other care which could have been provided by a *participating physician's* office, in the *outpatient* department of a *hospital*, or in another less costly location without adversely affecting the patient's condition or the quality of medical care rendered, unless the UM Committee has determined the care to be *medically necessary*. Nor will *ADVANTAGE* pay the cost of any service or article which is significantly more expensive than an available alternative, unless the UM Committee has determined the more expensive service or article has been demonstrated to be of significantly greater therapeutic value than the other, less expensive, alternative.

Circumstances Beyond *ADVANTAGE's* Control:

Neither, *ADVANTAGE*, nor *participating hospitals*, nor any *participating provider* shall have any liability or obligation for delay or failure to provide health care services:

- Due to causes beyond the control of *ADVANTAGE* or *ADVANTAGE's* *participating providers*. Such causes might include: complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant part of the *hospital personnel* or *health professionals*, or similar causes, under which the rendition of medical or *hospital* services hereunder is delayed or rendered impractical.
- Due to lack of available facilities or personnel if caused by disaster or epidemic.

In such events, *physicians and hospitals* shall render medical and *hospital* services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel as are then available.

SECTION 6: COMPLAINTS, GRIEVANCES AND APPEALS

GRIEVANCES – LEVEL 1

Members are encouraged to contact the Appeals Specialist at *ADVANTAGE* with any questions or *grievances*. *You* may request a *grievance* within 180 *calendar* days from the date of the initial adverse decision. Please address *your* request for a *grievance* to the Appeals Specialist at the address or telephone number listed on page 2 of this *Certificate*, or *you* may call us, toll-free, at (888) 806-1029 between the hours of 8 am through 5 pm, Monday through Friday, excluding holidays. *You* may also call the number on the back of *your* identification card for assistance in filing a *grievance*. Please include the following information in *your* correspondence, or have this information ready when telephoning:

Subscriber's Name
Patient's Name
Subscriber's Social Security Number
The Nature of the *Grievance*

When the *grievance* is received, it will be recorded in the *Grievance* Log so that it can be tracked and resolved. A confidential file will be opened and maintained throughout the case until resolution, documenting the substance of the *grievance* and actions taken. *You* have the right to submit written comments, documents, or other information relating to the *grievance*.

You shall receive an acknowledgment of *your grievance* within three working days after receipt of *your grievance*.

Grievances will be resolved according to the following time frames:

- Pre-service grievances: A pre-service *grievance* or appeal is a request to change an adverse determination for care or services in advance of the *member* obtaining the care or services. *ADVANTAGE* resolves pre-service *grievances* within 15 *calendar* days from receipt of the request at each level of review (first and second levels).
- Post-service grievances: A post-service *grievance* or appeal is a request to change an adverse determination for care or services that have already been received by the *member*. *ADVANTAGE* resolves post-service *grievances* within 20 business days after the *grievance* is filed. If we are unable to make a decision regarding the *grievance* within the twenty (20) day period due to circumstances beyond our control, then we shall: (1) notify *you* in writing advising of the reason for the delay before the twentieth business day, and (2) issue a written decision within an additional ten business days.

APPEALS LEVEL 2

If the *grievance* was not resolved to *your* satisfaction, *you* may appeal within 180 *calendar* days from the *grievance* decision by writing to the Appeals Specialist. Please address *your* request for an appeal to the Appeals Specialist at the address or telephone number listed on page 2 of this *Certificate*, or *you* may call us, toll-free, at (888) 806-1029 between the hours of 8 am through 5 pm, Monday through Friday, excluding holidays. *You* may also call the number on the back of *your* identification card for assistance in filing an appeal. Please include the following information in *your* correspondence, or have this information ready when telephoning:

Subscriber's Name
Patient's Name
Subscriber's Social Security Number
The Date of the Original *Grievance*
The Nature of the *Grievance*

You shall receive an acknowledgment of *your* request for a review by the second level Appeals Committee within three working days.

The appeal will be reviewed by the second-level Appeals Committee which, in the case of a *grievance* regarding medical care or treatment, will be composed of one or more individuals who have knowledge of the medical condition, procedure, or treatment at issue. The individual(s) will be in the same licensed profession as the *provider* who proposed, refused, or delivered the health care procedure, treatment, or service in question and who was not involved in the matter giving rise to the *grievance*.

If *you* wish to appear before the second-level Appeals Committee, *you* should make that request in the letter or telephone call requesting the appeal. *You* may also communicate with the Committee through other appropriate means if *you* are unable to appear in person. The Committee will meet during normal business hours. *You* may submit written comments, documents or other information relating to the appeal.

Appeals will be resolved according to the following time frames:

- Pre-service appeals: A pre-service *grievance* or appeal is a request to change an adverse determination for care or services in advance of the *member* obtaining the care or services. *ADVANTAGE* resolves pre-service appeals within 15 *calendar* days from receipt of the request at each level of review (first and second levels).

- **Post-service appeals:** A post-service *grievance* or appeal is a request to change an adverse determination for care or services that have already been received by the *member*. *ADVANTAGE* resolves post-service appeals within 30 *calendar* days from receipt of the request.

EXPEDITED GRIEVANCES AND APPEALS

Expedited *grievances* and appeals (Level I and Level II):

ADVANTAGE offers the *member* an expedited appeal for any *urgent care* request. *Urgent care* involves conditions which: “Could seriously jeopardize the life or health of the *member* or the ability of the *member* to regain maximum function, based on a prudent layperson’s judgment or in the opinion of a *physician* with knowledge of the *member’s* medical condition would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.”

ADVANTAGE must make the expedited *grievance* or appeal decision as expeditiously as the medical condition requires, but no later than 72 hours after the request at each level of review (Level I and Level II). An expedited review begins when a *member*, a representative of the *member*, or a practitioner acting on behalf of the *member* requests an expedited appeal either verbally, by facsimile, in writing or by any means of electronic communication. *ADVANTAGE* grants an expedited review to all requests concerning admissions, continued stay or other health care services for a *member* who has received *emergency services* but has not been discharged from the facility.

ADDITIONAL INFORMATION

Right to Receive Information

For any level of appeal, *you* are entitled to receive, upon request, reasonable access and copies of all documents relevant to the *grievance* or appeal. Relevant documents include documents or records relied upon in making the decision and documents and records submitted in the course of making the decision. *You* are entitled to receive, upon request, a copy of the actual benefit provision, guideline, protocol or similar criterion on which the decision was based.

Designating a Representative

A *member* may designate a representative to file a *grievance* for the *member* and to represent the *member* in the resolution and/or appeal of any *grievance* or appeal. *You* may need to sign a release in order to allow us to discuss *your* situation with *your* representative.

External Review

If *you* are dissatisfied with our decision of the second-level review, *you* may have the option of requesting an external review by an Independent Review Organization certified by the Indiana Department of Insurance. If *you* choose to request an external review of *your* appeal, send a notice in writing within 180 *calendar* days of receipt of the second-level decision. Per Indiana Code IC 27-13-10.1-1, *you* may request an external review for the resolution of *grievances* regarding:

1. an adverse utilization determination
2. an adverse determination of medical necessity; or
3. a determination that a proposed service is *experimental* or *investigational* made by a health maintenance organization or an agent of a health maintenance organization regarding a service proposed by a treating *physician*.

Please address *your* request for an external review to the Appeals Specialist at the address listed on page 2 of this *Certificate*:

Under the external review process, the Independent Review Organization will make a determination within 15 working days of *your* request, or for expedited requests, within 72 hours of receipt of *your* request. *You* may provide any requested information to the Independent Review Organization or authorize our release of information to the Independent Review Organization

You may be required to pay up to \$25.00 of the costs for the external review. *You* may not file more than one external review request for each *grievance*. If *you* have the right to external review under Medicare, *you* may not request external review through the plan.

QUESTIONS AND CONCERNS

Your satisfaction is very important to us. We have set up the *Grievance* Procedure to help ensure that any problem with any aspect of this Plan is addressed in a fair and timely manner. We fully expect to provide a fair settlement for every valid *grievance* in a timely fashion. However, if *you* feel *you* (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint *you* have been unable to resolve with *your* insurer *you* may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: (800) 622-4461 or
Indianapolis area: (317) 232-2395

Complaints can also be filed electronically at www.in.gov/idoi

You may also have remedies available to *you* through The Department of Labor and ERISA regulations.

SECTION 7: PAYMENT TO PROVIDERS AND CLAIMS FILING INFORMATION

Do I need to submit a claim for my in-network medical care?

No, *you* do not need to submit a claim. When *you* receive medical care from an *in-network participating provider*, including a *participating hospital*, that *participating provider* will submit all claims for *you*.

You must pay any *copayment* at the time of service. A *participating provider* may seek payment from *you* only for *deductibles*, *copayments*, *coinsurances* and for charges for *non-covered services*. Most of the time, *you* will not need to make a payment for *covered services*. After claims have been adjudicated, *your participating provider* will bill *you* for any services that are subject to *coinsurance*.

Do I need to submit a claim form for out-of-network care?

When services are provided by a *non-participating provider* or in the case of *emergency* medical services, *you* may need to pay the *provider* and then submit a claim. A *non-participating provider* may require *you* to pay any charges that are above the *Maximum allowable amount*. Please contact Member Services at the number shown on the Important Numbers page of this *Certificate*. They will provide instructions and a mailing address.

When will my claim be paid?

Claims will be paid within 45-days when filed on paper and 30 days when filed electronically after *ADVANTAGE* receives all information required to determine liability under the terms of this *Certificate*. If *ADVANTAGE* denies all or part *your* claim, *ADVANTAGE* (or *ADVANTAGE*'s designated agent) will provide *you* with a written notice that includes the reason(s) for denial.

When do I need to submit my claim?

A claim for a *participating provider* must be submitted within 90-days after the date the services are received or the date *you* made payment.

However, failure to give notice within the 90-day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within the period and that notice was given as soon as was reasonably possible.

Claims for *covered services* rendered by *providers not participating* with *ADVANTAGE* should be sent to the mailing address indicated in the "Network Administrator" section of *your ID card*. If a charge is made to *you* for any service that is reimbursable under the *Certificate*, written proof of such charge must be submitted to *ADVANTAGE* within 45-days after delivery of the service and must include an itemized statement plus diagnosis. Failure to furnish this documentation within the specific period will invalidate or reduce the claim unless, for a good reason, it was not possible to submit the claim within the specific period, and proof is produced on a timely basis as soon as possible thereafter.

ADVANTAGE will ordinarily make payment for *covered services* directly to the person or institution providing the services. However, if *you* furnish evidence that payment has been made by the *subscriber* to such person or institution for *covered services*, reimbursement will be made to the *subscriber* after deducting any payment made by *ADVANTAGE* before receipt of such evidence.

ADVANTAGE, at *ADVANTAGE*'s own expense, shall have the right and opportunity to examine the *member* whose sickness or *injury* is the basis of a claim as often as it may reasonably require during the claim period.

Claims disputed by *you* will be resolved by the procedures set forth in this *Certificate*.

What do I do if I receive a bill for in-network medical care?

If *you* should receive a bill for in-network medical services for which *you* are not responsible, please call Member Services at the number shown on the Important Numbers page of this *Certificate*.

SECTION 8: COORDINATION OF BENEFITS WITH OTHER COVERAGE

This *coordination of benefits (COB)* provision applies when a person has health care *coverage* under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determines which *plan* will pay as the primary plan. The primary *plan* that pays first pays without regard to the possibility that another *plan* may cover some expenses. A secondary *plan* pays after the primary *plan* and may reduce the benefits it pays so that payments from all *Group plans* do not exceed 100% of the total allowable expense.

Definitions

- A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated *coverage* for members for 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* insurance, closed panel or other forms of *Group* or *Group*-type *coverage* (whether insured or uninsured); *hospital* indemnity benefits in excess of \$100 per day; medical care components of *Group* long-term care contracts, such as skilled nursing care; medical benefits under *Group* or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
 - (2) "Plan" does not include: individual or family insurance; closed panel or other individual *coverage* (except for *Group*-type *coverage*); amounts of *hospital* indemnity insurance of \$100 or less per day; school accident type *coverage*, benefits for non-medical components of *Group* long-term care policies; Medicare supplement policies, Medicaid policies and *coverage* under other governmental *plans*, unless permitted by law.

Each contract for *coverage* under (1) or (2) 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*.

- The order of benefit determination rules determine whether this *plan* is "primary plan" or "secondary plan" when compared to another *plan* covering the person.

When this *plan* is primary, its benefits are determined before those of any other *plan* and without considering any other *plan*'s benefits. When this *plan* is secondary, its benefits are determined after those of another *plan* and may be reduced because of the primary *plan*'s benefits.

- "Allowable expense" means a health care service or expense, including *deductibles* and *copayments* that are covered at least in part by any of the *plans* covering the person. When a *plan* provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plans* is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expenses*:
 - (1) If a covered person is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the *plans* routinely provides *coverage* for *hospital* private rooms) is not an *allowable expense*.
 - (2) If a person is 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*.
 - (3) If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the primary *plan*'s payment arrangements shall be the *allowable expense* for all *plans*.
 - (4) The amount a benefit is reduced by the primary *plan* because a covered person does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred *provider* arrangements.
- "Claim determination period" means a *calendar year*. However, it does not include any part of a year during which a person has no *coverage* under this *plan*, or before the date this *COB* provision or a similar provision takes effect.
- "Closed panel *plan*" is a *plan* that provides health benefits to covered persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the *plan*, and that limits or excludes benefits for services provided by other *providers*, except in cases of emergency or referral by a panel member.
- "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the *calendar year* without regard to any temporary visitation

Order of Determination Benefits Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary *plan* pays or provides its benefits as if the secondary *plan* or *plans* did not exist.
- A *plan* that does not contain a *coordination of benefits* provision that is consistent with this regulation is always primary. There is one exception: *coverage* that is obtained by virtue of membership in a *Group* that is designed to supplement a part of a basic package of benefits may provide that the supplementary *coverage* shall 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 superimposed over base *plan hospital* and surgical benefits, and insurance type *coverage*'s 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 determining its benefits only when it is secondary to that other *plan*.
- The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.
 1. Non-Dependent or Dependent. The *plan* that covers the person other than as a dependent, for example as an employee, *member*, *subscriber* or retiree is primary and the *plan* that covers the person as a dependent is secondary. However, if the

person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *plan* covering the person as a dependent; and primary to the *plan* covering the person 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 the person as an employee, *member*, *subscriber* or retiree is secondary and the other *plan* is primary.

2. Child Covered Under More Than One *Plan*. The order of benefits when a child is covered by more than one *plan* is:
 - a. The primary *plan* is the *plan* of the parent whose birthday is earlier in the year if:
 - The parents are married;
 - The parents are not separated (whether or not they ever have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.If both parents have the same birthday, the *plan* that covered either of the parents longer is primary.
 - b. If the specific terms of a court decree state that one of the parents is responsible for the 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 *claim determination periods* or *plan* years commencing after the *plan* is given notice of the court decree.
 - c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - The *plan* of the *custodial parent*;
 - The *plan* of the *spouse* of the *custodial parent*;
 - The *plan* of the *non-custodial parent*; and then
 - The *plan* of the *spouse* of the *non-custodial parent*.
3. Active or Inactive Employee. The *plan* that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working *spouse* will be determined under the rule labeled B (1).
4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an employee, *member*, *subscriber* or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of coverage. The *plan* that covered the person as an employee, *member*, *subscriber* or retiree longer is primary.
6. If the preceding rules do not determine the primary *plan*, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan* under this regulation. In addition, this *plan* will not pay more than it would have paid had it been primary.

Effect on the Benefit of this Plan

- When this *plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *plans* during a *claim determination period* are not more than 100 percent of total *allowable expenses*. The difference between the benefit payments that this *plan* would have paid had it been the primary *plan* and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this *plan* to pay any *allowable expenses*, not otherwise paid during the *claim determination period*. As each claim is submitted, this *plan* will:
 1. Determine its obligation to pay or provide benefits under its contract;
 2. Determine whether a benefit reserve has been recorded for the covered person; and
 3. Determine whether there are any unpaid *allowable expenses* during that claims determination period.

If there is a benefit reserve, the secondary *plan* will use the covered person's benefit reserve to pay up to 100% of total *allowable expenses* incurred during the *claim determination period*. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new *claim determination period*.

- If a covered person is 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 shall 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*. ADVANTAGE 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. ADVANTAGE need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give ADVANTAGE any facts it needs 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, ADVANTAGE 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*. *ADVANTAGE* 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 reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by *ADVANTAGE* is more than it should have paid under this *COB* provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 9: SUBROGATION/RIGHT OF REIMBURSEMENT

Subrogation means: If *your injury* or *illness* is caused by the acts or omissions of another party (including insurance *carriers* who are so liable), and *ADVANTAGE* has provided benefits under this *Certificate*, *ADVANTAGE* will have the right to be reimbursed if *you* receive any payment from the other party.

- *ADVANTAGE* is subrogated to all of *your* rights against any party legally liable to pay for *your injury* or *illness*.
- *ADVANTAGE* may assert this right independently of *you*.
- *You*, or anyone acting legally on *your* behalf must:
 - fully cooperate with *ADVANTAGE* in order to protect *ADVANTAGE*'s subrogation rights;
 - give notice of *ADVANTAGE*'s claim to third parties and their insurers who may be legally responsible;
 - provide *ADVANTAGE* with relevant information and sign and deliver such documents as *ADVANTAGE* reasonably request to secure *ADVANTAGE*'s subrogation claim; and
 - obtain *ADVANTAGE*'s consent before releasing any party from liability for medical expenses or services paid or provided.

If *you* enter into litigation or settlement negotiations regarding the obligations of other parties, *you* must not prejudice, in any way, *ADVANTAGE*'s subrogation rights.

SECTION 10: TERMINATION OF COVERAGE

The *coverage* provided in this *Certificate* for *you* and *your eligible dependents* and *young adults*, if any, may be terminated by *ADVANTAGE* upon the occurrence of any of the following events:

- You revoke your consent for *ADVANTAGE* to utilize your personal medical information for future, known, or routine needs for the purpose of treatment, payment, and health care operations.
- The termination of the *Contract* between *your Group* and *ADVANTAGE*.
- The *Group* fails to pay *ADVANTAGE* *premium* due on *your* behalf.
- *You* no longer qualify for eligibility based on the requirement of working or residing within the defined *ADVANTAGE* *service area*.
- Upon thirty-one (31) days prior written notice by *ADVANTAGE* if:
 - *You* fail to pay *copayments* or *coinsurance* required for *covered services*, or *premium* contributions, if any; or
 - *You* are unable to establish and maintain a satisfactory *hospital* or *patient-health professional* relationship with *participating hospitals* and *health professionals*; or
 - *You* commit fraud against *ADVANTAGE* or a *participating provider* by, for example:
 - Allowing a non-member to use *your ADVANTAGE ID card* to obtain services;
 - Making any false statement or representation on *your* membership application;
 - Falsifying a prescription, stealing or otherwise misappropriating a prescription blank(s) or other property of a *participating provider* of *ADVANTAGE*;
 - Altering *your* medical record; or
 - Obtaining similar drug therapy or prescriptions from two or more *providers*, without *proper referral* or without informing the *providers* of *your* complete prescription profile, when done for the purpose of providing such prescriptions to someone other than the person for whom the medication was intended or for the purpose of self-administration of multiple prescriptions without the knowledge or approval of *your PCP*.
- *You* behave in a violent or abusive manner toward the staff of an *ADVANTAGE* *participating physician*, a *provider network*, or *ADVANTAGE*;
- *You* otherwise repeatedly violate the terms of this *Certificate* or *ADVANTAGE* rules; or
- *You* fail to cooperate with *ADVANTAGE* in the administration of the *coordination of benefits* provisions set forth in this *Certificate*.
- For other good cause as may from time to time be permitted by law. If membership is terminated for any of the grounds specified in this section, all rights to service cease as of the date of termination and there is no right to convert to an individual *carrier*.
- *Your spouse* will cease to be eligible for *coverage* hereunder on the first of the month following the month in which a final decree of dissolution of the marriage is recorded, unless *coverage* is continued in accordance with the terms of this *Certificate* or unless terminated sooner pursuant to the terms of this *Certificate*.

- If *you* are eligible to be covered under Medicare, *you* must enroll in Part A and Part B Medicare *coverage* on the date eligible in order to continue *coverage* under this *Certificate*. An exception to this rule applies to an actively employed *member* or the *spouse* of an actively employed *member* when *ADVANTAGE* is the primary payor. “Deemed Entitlement to Medicare” means any Covered Person who is an eligible retiree or the *spouse* of an eligible retiree shall be deemed to have enrolled for all Medicare Part A and Part B *Coverage* for which such Covered Person is eligible at the time such Covered Person first becomes eligible as if such Covered Person were enrolled in all such Medicare *Coverage*. In cases where Medicare is primary, the Plan estimates Medicare’s primary share and pays only the secondary charges.
- *Your* child’s *coverage* will terminate once he/she has reached the attainment of the limiting age, unless *coverage* is extended as described in the “Eligibility, Enrollment, *Coverage*” Section of this *Certificate* or is terminated sooner due to the terms of this *Certificate*. If *you* wish to obtain coverage under the Young Adult Coverage Rider *you* must notify your employer within 31 days of the dependent reaching the limiting age otherwise coverage will terminate.
- Termination of *coverage* for *you* and any enrolled family members, including a *young adult* due to termination of employment shall be determined by the *Group*; not withstanding any continuation of *coverage* addressed elsewhere in this *Certificate*.

If *you* believe that *coverage* has been canceled or not renewed because of *your* health status, need for health care services or exercise of *your* rights under the *grievance* procedure, *you* may request review by *ADVANTAGE* or by the Department of Insurance. Please refer to the “*Grievances and Appeals*” Section of this *Certificate*.

In the event of the termination of the *Contract* between *Group* and *ADVANTAGE* or enrollment termination of any individual *member*, *coverage* for any prescription medication provided for under this *Certificate* will only be provided for the specific quantity of prescription medication that will actually be used or consumed by the *member* through the last day of eligibility, regardless of the pharmacy source for the medication. *Member* will be financially responsible for all quantities of prescription medication that will be used or consumed after the last day of eligibility, even if that medication is dispensed as part of a prescription partially covered by this *Certificate* prior to the termination.

Voluntary termination

- If *you* choose *coverage* under any other Plan that is offered by, through, or in connection with *your Group*, in lieu of *coverage* with *ADVANTAGE*, *coverage* for *you* and *your eligible dependents* will terminate on the date and time that the other *coverage* becomes effective. *Your Group* agrees to notify *ADVANTAGE* immediately when *you* elect other *coverage*.
- *You* may terminate *your coverage* and *your eligible dependent’(s)’* or *young adult’(s)’ coverage*, if there is a qualified change in family status or during open enrollment, by giving written notice to *your Group*. The termination shall be effective on the last day of the month upon receipt of such notice by *ADVANTAGE* unless otherwise specified.

Your coverage (and *dependents* or *young adults* if applicable) shall terminate on the date determined by *your Group*.

Certificates of Creditable Coverage

If *your coverage* with *ADVANTAGE* terminates, *you* may be asked by the replacement *carrier* for a Certificate of *Creditable Coverage*. “*Creditable Coverage*,” with respect to an individual, is *coverage* of the individual under any of the following types of insurance plans:

- a *Group* health plan or individual health plan;
- Part A or B of Medicare;
- Medicaid;
- CHAMPUS;
- a medical care program of the Indian Health Service or tribal organizations;
- a state health benefits risk pool, such as Children’s Health Insurance Program;
- the federal employees health benefits program;
- a public health plan; (a plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance *coverage* to individuals);
- a health benefit plan under the Peace Corps Act; or
- a church plan.

In the event that *you* disenroll from *ADVANTAGE*, the Certificate of *Creditable Coverage* will help *your* new insurance *carrier* determine to what extent its *preexisting medical condition* exclusions apply, if any. If *you* were not without *coverage* for more than 63 days, the new insurance company must reduce its *preexisting medical condition* exclusions under *your* new insurance policy. *ADVANTAGE* will provide *you* with a Certificate of *Creditable Coverage* upon *your* disenrollment that will show the *effective date* of *your coverage* with *ADVANTAGE*. *ADVANTAGE* will make these Certificates available when:

- *You* are no longer eligible with *ADVANTAGE*;
- *You* reach the end of Consolidated Omnibus Budget Reconciliation (COBRA) *coverage*; and/or
- Upon *your* request, but only if the request is made within 24 months after *coverage* ends. *ADVANTAGE* will also provide to *your* new insurance *carrier*, upon request, a *Certificate* explaining *your* benefits under *ADVANTAGE*

SECTION 11: CONTINUATION OF COVERAGE

Do I have the option of continuing my *coverage* after termination?

- **Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986**

If *you* are covered under a *Group* which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, the following shall apply:

In order to obtain COBRA to continue *coverage* under this *Certificate*, *your Group* must:

- notify *you* of *your* right to continued *Group coverage*, as required by federal law;
- notify *ADVANTAGE* as soon as possible when *you* elect COBRA, including the date *your COBRA coverage* becomes effective;
- collect and forward all applicable *premiums* to *ADVANTAGE* on a timely basis.

If *you* have any questions about COBRA, *you* should speak with *your Group* directly.

- **Continuation of Coverage under Disability**

You may become totally disabled while covered under this *Certificate* and still be totally disabled at the time this *Certificate* terminates or non-renews. If so, and if *you* pay the *premiums* that apply, *you* will be allowed to extend *your* benefits, under this *Certificate*, for the condition causing such disability, until the sooner of:

- The date *you* become covered under, or eligible to be covered under, another *carrier* or policy affording similar benefits;
- A period of three (3) months from the date *coverage* hereunder would have otherwise ended had *you* not been so disabled; or
- The date *you* cease to be totally disabled.

Benefits will not be said to be “similar” if *you* would be subject to a *pre-existing medical condition* or waiting period covering the disabling condition under the replacement policy. For the purposes of this *Certificate*, “total disability” means a disease or bodily *injury* (excluding normal pregnancy) which, in fact prevents or may reasonably be expected to prevent *you* from engaging, for a period of at least one (1) year, in any work for which *you* are or become qualified by reason of education, training or experience; or which prevents or may be expected to prevent *you* from performing, for a period of at least one (1) year, the important activities normal for a person of that age and family status. The fact that *you* are in the *hospital* at the time the *Certificate* ends is not by itself proof of “total disability”. Nothing in this Section shall be deemed to prevent *ADVANTAGE* from coordinating benefits with the prior *carrier* or with another *Group carrier* with whom a totally disabled *member* may have health care *coverage*.

- **Individual Conversion**

You may be eligible to obtain Individual Conversion *coverage* after *your* benefits with *your Group*, *ADVANTAGE* and/or COBRA expire. The *Individual Conversion Contract* is provided through *ADVANTAGE* Health Solutions, Inc. To obtain more information, contact *ADVANTAGE* Health Solutions at 9045 River Road, Ste 200 Indianapolis IN 46240, 1-800-553-8933.

You may be entitled to an *Individual Conversion Contract*, without evidence of insurability, if:

- *You* meet the eligibility requirements for an *Individual Conversion Contract* pursuant to Indiana Code 27-8-15-31;
- *You* were continuously covered under this *Certificate* for at least 90-days;
- *You* request the conversion policy from *ADVANTAGE* within 30 days of loss of *coverage*; and
- *You* cease to be covered under this *Certificate* as a result of:
 - leaving *your Group* or a reduction in *your* hours of employment;
 - the *subscriber's* death or termination of marriage; or
 - ceasing to meet the definition of *eligible dependent*.

If eligible for COBRA *coverage*, *you* must exhaust COBRA *coverage* before requesting a conversion policy. The conversion policy will be issued without regard to health status or requirements for health care services. If *you* elect to exercise this conversion privilege, the conversion shall be effective retroactive to the date and time *coverage* terminated under this *Certificate*, subject to the payment of any applicable *premium* due.

You must pay *ADVANTAGE*, less any *copayment* and *coinsurance*, for the reasonable value of health services or benefits provided under this *Certificate* during the 30-day election period, if the conversion privilege is not exercised.

- **Extension of Coverage If You Are Confined to the Hospital**

If *you* are *hospitalized* for a medical or surgical condition on the date of termination of this *Certificate*, *you* will have continuation of *coverage* for *inpatient* services until the sooner of:

- *Your* discharge from the *hospital*;
- Sixty (60) days pass after the termination date of this *Certificate* ;
- *You* obtain *coverage* from another *carrier* which includes *coverage* for *inpatient* services provided by this *Certificate* ;
- Termination of *your Group's* *Group Service Agreement* by *ADVANTAGE*, as determined by:

- The *effective date* specified in written communication sent to *ADVANTAGE* by *your Group*, or
- Failure to pay a *premium* within the grace period permitted under the *Group Service Agreement*.
- Termination of *your coverage* and this *Certificate* by *ADVANTAGE* due to:
 - *You* knowingly providing false information to *ADVANTAGE*;
 - *Your* failure to comply with the rules stated in this *Certificate* ; or
 - *You* fail to pay *premium* within the grace period permitted in *your Group's Group Service Agreement*.

- **Exceptions to Continuation of Coverage and Conversion**

Neither *you* nor *your eligible dependents* will be eligible for continuation of *coverage* under COBRA or for conversion to an *Individual Conversion Contract* if any of the following circumstances apply:

- *You* do not meet the eligibility guidelines for an *Individual Conversion Contract* set forth in Indiana Code 27-8-15-31;
- *Coverage* was terminated by *ADVANTAGE* or *your Group*; or
- *You* have moved out of the geographic area in which *ADVANTAGE* is licensed to operate (Applies to individual conversion only).

In the event that *you* are deemed ineligible for conversion, *your eligible dependents* will also be deemed ineligible for conversion, unless otherwise required by law.

SECTION 12: OTHER IMPORTANT INFORMATION

Care Management

ADVANTAGE is committed to providing *members* with highest quality of care in the most cost-effective manner. In order to meet this endeavor, *ADVANTAGE* manages care using the following:

- Proper Referral Process – If services are not available within the *participating provider network*, *ADVANTAGE* will work with the *member* and *referring physician* to refer the *member* to the appropriate *provider* of service based on their condition.
- Pre-Certification – Pre-approval or certification of certain services (i.e. Physical Therapy, *Hospitalizations*, etc.). *Your referring physician* is responsible for obtaining any *pre-certifications* unless *you* are a Point of Service *member*, where this is *your* responsibility.
- Concurrent Review – A review conducted of all *inpatient* admissions to assess whether there is a need for a continued stay. This process ensures that *members* only stay as long as *medically necessary* and at the same time are not discharged prior to necessity.
- Discharge Planning – This process is in place to ensure appropriate and timely discharge from the *hospital* to a more appropriate level and setting of care such as home health care.
- Case Management – This program is designed to be used in cases of *members* who are in need of long term care. A nurse is assigned to the *member* to work with the *member's physicians* and the *member* about a treatment plan. The patient, *provider* and Case Manager must all agree on the most cost effective treatment method, while assuring quality medical care.
- Preventive Health – Each of *ADVANTAGE's* benefit plans offer preventative health benefits designed to promote wellness and early detection of potential health problems.
- Disease Management – *ADVANTAGE* empowers *members* who have conditions like Asthma, Hypertension, Cardiac Heart Failure, Depression, and Diabetes by providing them information on their condition to assist them with their conditions. *ADVANTAGE* provides them with newsletters and other materials on their conditions. Also, a member can choose to enroll and actively participate in *ADVANTAGE's* Disease Management to receive discounted copays for certain disease-specific medications.

Provider Termination

- Occasionally, a *physician* may no longer participate with *ADVANTAGE* due to retirement, death, relocation, termination, etc. If *your PCP* or *SCP* ceases to be an *ADVANTAGE participating provider*, *ADVANTAGE's* Member Services Department will make good faith efforts to notify *you* within 30 days prior to the *effective date* of termination. *You* will receive instructions on how to select a new *physician*.
- If *you* are currently in active treatment with the terminating *physician*, or *you* are in *your* third trimester of pregnancy, please contact an *ADVANTAGE* Member Services Representative. *You* may be able to continue *your* care with the *physician* until the completion of *your* treatment or up to 90-days, whichever is shorter. A representative will assist *you* or direct *you* to *ADVANTAGE's* Care Coordinator. *ADVANTAGE's* goal is to ensure *you* have access to continuity of care until *your* current treatment plan has ended, or until *your* pregnancy has been delivered.
- If *you* need an updated *Provider Directory* or other assistance in selecting a *physician*, *ADVANTAGE's* Member Services Department will help *you*.

- Upon termination of a contract with a *participating provider*, *ADVANTAGE* shall be liable for payment of *covered services* rendered by the *provider* to *you* under the care of the *provider* at the time of termination until services being rendered to *you* by the *provider* are completed, unless *ADVANTAGE* makes reasonable and medically appropriate provision for assumption for services by another *provider*.

Notice of Material Provider Change

ADVANTAGE will provide written notice to *you*, within a reasonable time, after learning of an action by a *participating provider* that has a material effect on the *Group* or *you*. Examples of such actions may include: leaving *ADVANTAGE*'s *participating provider network*; material breach of contract; or being unable to perform key contract terms, but only if any of those actions affects *you* in a material way.

Utilization Management (UM) Decision Maker

- UM decision making is based only on appropriateness of care and service and existence of *coverage*.
- *ADVANTAGE* does not specifically reward *providers* or other individuals for issuing denials of *coverage* or service care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Medical Technology Assessment

- *ADVANTAGE* provides a process to evaluate new medical technologies, services and pharmacological treatment to assure appropriate access to such services by the *member* population. *ADVANTAGE* develops protocols for new technology proactively and reactively. As *ADVANTAGE* becomes aware of new technology, the new technology guidelines outlined in this process are followed to prepare *ADVANTAGE*'s position regarding the new technology in anticipation of a future request.
- The *member's physician* must request an approval, prior to the service date and in writing, regarding the recommended treatment or service that is a new medical technology, *experimental* or investigative treatments and services.
- *ADVANTAGE* has available participating specialists, sub-specialists, pharmacists, and a referral center (Hayes, Inc.) to assist with the review and determination regarding new medical technology.
- *ADVANTAGE* contracts with Hayes, Inc. to provide a database and access to research regarding various medical technologies, including new use of existing technologies and newly developed technologies. Elements of the Hayes technology assessment process include:
 - Application of rigorous methods of scientific inquiry which encompass a thorough search of the peer-reviewed scientific literature
 - Critical appraisal of the data reported with respect to study design and clinical significance of outcomes
 - Comparative analysis of alternatives

There are many healthcare technologies assessed by Hayes, Inc. and accessible to *ADVANTAGE* including:

- Medical and surgical procedures, including transplants
- Drugs and pharmaceuticals
- Diagnostic and screening tests
- Alternative therapies
- Behavioral Health procedures
- Medical devices/equipment
- Requests for approval of new medical technology procedures/services that involve a *member* whose health situation is life threatening will be resolved and the *physician/member* notified within 72 hours of the request.
- Technology assessments for non-urgent situations should be submitted 5-7 days prior to the service date if possible to allow adequate time to investigate the proposed treatment or service. A response to a written request for non-urgent technology assessment is provided within 15 *calendar* days of receiving the request. Medical Management notifies the *PCP*, *SCP*, and facility by telephone of the recommendation to approve or deny *coverage* within one business day. Notification letters are mailed to the *PCP*, *SCP*, and *member* within two (2) business days of the determination to approve or deny new medical technology.
- If the Medical Director denies a request for a new technology service/procedure, a denial notification letter is sent to the *member*, *PCP*, and *SCP* outlining the principle reason for the denial, criteria utilized, and the appeals process.

Severability

In the event that any provision of this *Certificate* is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this *Certificate*, which shall continue in full force and effect in accordance with its remaining terms.

Worker's Compensation

This *Certificate* is not in lieu of and does not affect any requirement or *coverage* by Worker's Compensation Insurance.

Rights to Covered services Not Transferable

No person other than *you* or *your eligible dependent* is entitled to receive health care services or other benefits to be furnished by *ADVANTAGE* under this *Certificate*. The right to health care services or other benefits is not transferable.

Right to Change Control when required by Law

ADVANTAGE will apply this *Certificate* in agreement with state and federal laws and regulations. If any part of this *Certificate* does not agree with state or federal laws or regulations, this *Certificate* is deemed amended and *ADVANTAGE* will change *ADVANTAGE*'s procedures to conform to the laws and regulations. *ADVANTAGE* reserves the right to terminate the *Contract* and re-rate the *Contract* based on the changes at the time of renewal of this *Certificate*.

Assignment of Benefits Payments

You are not permitted to assign benefits or payments for services covered under this *Certificate*.

Relationship Among Parties Affected by this Certificate

- The relationship between *ADVANTAGE* and participating *health professionals* and/or *provider networks* is that of independent contractors. *ADVANTAGE* is not a "professional" corporation and so does not practice medicine or direct the professional practice of medicine by any *health professional*. Neither participating *health professionals* nor *provider networks* are employees of *ADVANTAGE*, nor are they agents of *ADVANTAGE*. Nor is *ADVANTAGE* or any of *ADVANTAGE*'s employees an employee or agent of the *health professionals* or *provider networks* who participate in *ADVANTAGE*'s provider panel. *Health professionals* are responsible for maintaining professional-patient relationships with the *member*. *Health professionals* are solely responsible to the *member* for all medical services.
- *Participating providers* may receive a financial incentive from *ADVANTAGE* to appropriately manage the provision and cost of services rendered to *you*.
- Neither the *Group*, nor any *member*, is an agent or representative of *ADVANTAGE*. Neither the *Group*, nor any *member*, shall be liable for any acts or omissions of *ADVANTAGE*, *ADVANTAGE*'s agents or employees, or of any *participating health professional*, or *participating hospital*, or any other person or organization with which *ADVANTAGE*, *ADVANTAGE*'s agents or employee, has contracted for the performance of services under this *Certificate*.
- Certain *members* may, for reasons personal to themselves, refuse to accept procedures or courses of treatment recommended by an *ADVANTAGE participating health professional*. *Health professionals* shall use their best efforts to render all necessary and appropriate professional services in a manner compatible with the *member's* wishes, insofar as this can be done consistently with the *participating health professional's* judgment as to the requirements of proper medical practice. If a *member* refuses to follow a recommendation treatment or procedure, and a *participating health professional* believes that no professionally acceptable alternative exists, such *member* shall be so advised. The *member* will have the right to consultation (*second opinion*) from an appropriate *ADVANTAGE participating physician* regarding his or her medical condition. If both *participating physicians* agree as to the course of treatment, and the *member* still refuses to follow the recommendation, *ADVANTAGE* will cease to *provide covered services* or pay for treatment for such condition. At such time the *member* agrees to follow the recommended treatment or procedure, *covered services* will resume.

SECTION 13: NOTICE OF PRIVACY PRACTICES

ADVANTAGE is required by applicable federal and state laws to maintain the privacy of *your* health information. We are also required to give *you* this notice about our privacy practices, our legal duties, and *your* rights concerning *your* health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2005, and will remain in effect until we replace it.

ADVANTAGE reserves the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. *ADVANTAGE* reserves the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information *ADVANTAGE* created or received before we made the changes. Before we make significant change in our privacy practices, *ADVANTAGE* will change this notice and send the new notice to our health *subscribers* at the time of the change.

You may request a copy of our notice at any time. If *you* would like to request a copy or obtain additional information, please contact us using the contact information listed at the end of this notice.

Uses and Disclosures of Health Information

The sections below describe the ways *ADVANTAGE* uses and releases *your* health information. *Your* health information is not shared with anyone who does not have a "need to know" to perform one of the tasks listed below.

- **Treatment:** *ADVANTAGE* may use *your* health information or disclose it to third parties to coordinate and oversee *your* medical care. For example, we may use *your* health information to help *you* find a doctor or a *hospital* that can treat *your* specific health needs.

- **Payment:** *ADVANTAGE* may use *your* health information or disclose it to third parties to pay for *your* medical care. For example, we may use *your* health information when we receive a claim for payment. *Your* claims tell us what services *you* received and may include a diagnosis. *ADVANTAGE* may also disclose this information to another insurer if *you* are covered under more than one health plan.

NOTE: Non-English speaking *members* can access Member Services, Utilization Management and Care Coordination, and other *ADVANTAGE* services for *member* treatment, payment or *ADVANTAGE* operations. *ADVANTAGE* contracts with Language Line Services to assist non-English speaking *members* in accessing *ADVANTAGE* resources and getting answers to questions. The interpreters may communicate directly with the *member* and *ADVANTAGE* representatives to resolve *member* questions. The communication may include information related to *your* health care. As concepts familiar to English speakers often require explanation or elaboration in other languages and cultures, the interpreters will then convey the communications meaning-for-meaning not necessarily word-for-word.

- **Health Care Operations:** *ADVANTAGE* may use *your* health information and disclose it to third parties in order to assist in *ADVANTAGE*'s everyday work activities such as looking at the quality of *your* care, carrying out utilization review, and *ADVANTAGE*'s business planning. For example, *your* health information may be released to members of *ADVANTAGE* staff to review the quality of care and outcomes. *Your* health information may be released to doctors or doctor groups involved in *your* care to improve patient care. Additionally, *ADVANTAGE* publishes the Health Group Data Information Set (HEDIS) which is a report of *ADVANTAGE member's* health care measurement data. *ADVANTAGE* also publishes the Commercial Adult Health Plan Survey (CAHPS) results, which measures *ADVANTAGE member* satisfaction. *ADVANTAGE*'s policy reflects that we utilize methodologies that protect the identity of individual *members*, such as not connecting specific survey responses to individual *members*, not providing any *member* specific data in the measurement data, etc.

NOTE: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to inform you of your right, our legal duties and our privacy practices. By enrolling in this Plan, *you* understand that *ADVANTAGE* has the right to utilize *your* personal medical information for future, known or routine needs for the purposes of treatment, payment, and health care operations. ***You understand this consent is a condition of your enrollment in ADVANTAGE and you have the right to revoke this consent in writing at any time.***

- **To You and Upon Your Authorization:** *ADVANTAGE* must disclose *your* health information to *you*, as described in the Individual Rights section of this notice, below. *You* may give us written authorization to use *your* health information or to disclose it to anyone for any purpose. If *you* give us an authorization, *you* may revoke it in writing at any time. *Your* revocation will not affect any use or disclosure permitted by *your* authorization while it was in effect. Without *your* authorization, we may not use or disclose *your* health information for any reason except those described in this notice
- **To Spouse or Parent:** Unless *you* specifically request that *ADVANTAGE* not disclose such information, *ADVANTAGE* may disclose *your* health information to *your spouse* or parent, in compliance with applicable privacy laws, to help with *your* health care or payment for health care services. *Your* request to not disclose health information to a *spouse* or parent must be in writing, signed by the individual authorized to make such a request, and sent to the Contact Information listed at the end of this notice.
- **To Plan Sponsor (Group):** *ADVANTAGE* may disclose limited summary health information about *you* to *your* plan sponsor (*Group*). "Summary Health Information" is information that summarizes the claims history, claims expenses or types of claims experienced by *you* and other members of *your Group* health plan, from which specific identifiers have been deleted. However, *ADVANTAGE* may disclose *your* identifiable health information and the identifiable health information of others enrolled in *your Group* health plan to *your* plan sponsor (*Group*) only:
 1. If *you* authorize us to disclose the information by completing an authorization form; or
 2. If necessary for the *Group* to perform plan administration functions on behalf of the *Group* health plan, and *ADVANTAGE* receives a certification from the plan sponsor (*Group*) that satisfies all of the requirements of HIPAA, which allow for the release of identifiable health information.
- **To Family and Friends:** If *you* agree, or if *you* are unavailable to agree, when the situation, such as medical *emergency* or disaster relief, indicates that disclosure would be in *your* best interest, *ADVANTAGE* may disclose *your* health information to a family member, friend or other person to the extent necessary to help with *your* health care services.
- **Underwriting:** *ADVANTAGE* may receive *your* health information for underwriting, *premium* rating or other activities relating to the creation, renewal or replacement of a *Contract* of health insurance or health benefits. We will not use or further disclose this health information for any other purpose, except as required by law, unless the *Contract* of health insurance or health benefits is placed with us. In that case, our use and disclosure of *your* health information will only be as described in this notice.
- **Marketing:** *ADVANTAGE* may use *your* health information to contact *you* with information about health-related benefits and services, including but not limited to, *ADVANTAGE*'s disease management programs and *quality improvement* activities that may be of interest to *you*. We may disclose *your* health information to a business associate to assist us in these activities. Unless the information is provided to *you* by a general newsletter, in person, or is for products or services of nominal value, *you* may opt-out of receiving further such information by telling us using the contact information listed at the end of this notice.

- **Research; Death; Organ Donation:** *ADVANTAGE* may use or disclose *your* health information for research purposes in limited circumstances. We may disclose the health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.
- **Public Health and Safety:** *ADVANTAGE* may disclose *your* health information to the extent necessary to avert a serious and imminent threat to *your* health or safety or the health or safety of others. We may disclose *your* health information to a government agency authorized to oversee the health care system or government programs or its contractors, and public health authorities for public health purposes. We may disclose *your* health information to appropriate authorities if we reasonably believe that *you* are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law:** *ADVANTAGE* may use or disclose *your* health information when we are required to do so by law. For example, we must disclose *your* health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy law. We may disclose *your* health information when authorized by workers' compensation or similar laws.
- **Process and Proceedings:** *ADVANTAGE* may disclose *your* health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose *your* health information to law enforcement officials.
- **Law Enforcement:** *ADVANTAGE* may disclose limited information to a law enforcement official concerning the health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the health information of any inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- **Military and National Security:** *ADVANTAGE* may disclose to Military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Other Uses of Health Information – By Authorization Only

Other uses and disclosures of health information not covered by this Notice or the law that apply to us will be made only with *your* written authorization. If *you* provide us with an authorization to use or release health information about *you*, *you* may end that authorization, in writing, at any time. If *you* end *your* authorization, we will no longer use or release health information about *you* for the reasons covered by our written authorization. *You* understand that we are unable to take back any disclosures we have already made with *your* authorization.

A parent, legal guardian, or properly named patient advocate may represent *you* if *you* cannot provide an authorization. Authorization is needed for certain release of information dealing with mental health issues, substance abuse issues, HIV/AIDS and *grievances*. We can provide *you* with a sample authorization form. *You* may also end an authorization by writing to *ADVANTAGE* at the contact information list at the end of this Notice.

Confidentiality in All Settings

ADVANTAGE has policies and procedures in place that protect the privacy of *your* information.

- Every employee signs a statement when they are hired that they understand they are required to keep *member* information private. They also learn about the actions the company will take if the privacy policies are not followed.
- *ADVANTAGE* has strict control of access to electronic, and paper information specific to *members*. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for *members*.

ADVANTAGE tells all third parties with whom we share information about our privacy policies. These third parties must follow our privacy policies unless they have policies of their own equal to ours. In addition, *ADVANTAGE* will not share any *member* information with a *Group* without specific authorization from the *member*.

ADVANTAGE's Compliance Committee reviews our confidentiality policies and procedures every year. These committees also reviews how we collect, use, dispose of, and disclose *your* information. *Members* (or prospective *members*) and *providers* have the right to review *ADVANTAGE*'s privacy policies and procedures. *You* may get copies by contacting Member Services.

Changes to this Notice

ADVANTAGE has the right to change the terms of this Notice. We have the right to make these changes, which apply to health information we already have about *you* as well as any we receive in the future. We will always post a copy of the current Notice on *ADVANTAGE*'s web site. *You* will also receive materially revised Notices within 60 days of their effective date.

Individual Rights

- **Access:** *You* have the right to inspect or obtain copies of *your* health information, with limited exceptions. *You* may request that *ADVANTAGE* provide copies in a format other than photocopies (i.e. electronic). We will use the format *you* request unless we cannot practicably do so.

- **Disclosure Accounting:** *You* have the right to receive a list of instances in which *ADVANTAGE* or our business associates disclosed *your* health information obtained or created since April 14, 2003 for purposes other than treatment, payment or health care operations and certain other authorizations. We will provide *you* with the date(s) on which we made the disclosure, the name(s) of the person or entity (ies) to whom we disclosed *your* health information, a description of the health information disclosed, and certain other information. If *you* request this list more than once in 12-month period, we may charge *you* a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
- **Restriction Request:** *You* have the right to request that *ADVANTAGE* place additional restrictions on our use or disclosure of *your* health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our *Agreement* (except in an *emergency*). Any *Agreement* *ADVANTAGE* may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an *Agreement* on *your* behalf. *ADVANTAGE* will not be bound unless our *Agreement* is so memorialized in writing.
- **Confidential Communication:** *You* have the right to request that *ADVANTAGE* communicate with *you* in confidence about *your* health information by alternative means or to an alternative location. *You* must inform us that confidential communication by alternative means or to an alternative location is required to avoid endangering *you*. *You* must make *your* request in writing, and *you* must state that the information could endanger *you* if it is not communicated in confidence by the alternative means or to the alternative location *you* want. *ADVANTAGE* must accommodate *your* request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect *premiums* and pay claims under *your* health plan.
- **Amendment:** *You* have the right to request that *ADVANTAGE* amend *your* health information. *Your* request must be in writing, and it must explain why the information should be amended. *ADVANTAGE* may deny *your* request if we did not create the information *you* want amended or for certain other reasons. If we deny *your* request, we will provide *you* a written explanation. *You* may respond with a statement of disagreement to be appended to the information *you* wanted amended. If we accept *your* request to amend the information, we will make reasonable efforts to inform others, including people *you* name, of the amendment and to include the changes in any future disclosures of that information.
- **Electronic Notice:** If *you* receive this notice on our web site (www.advantageplan.com) or by electronic e-mail, *you* are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If *you* are concerned that we may have:

- Violated *your* privacy rights;
- *You* disagree with a decision we made about access to *your* health information;
- In response to a request *you* made to amend or restrict the use or disclosure of *your* health information; and/or
- In response to a request *you* made to have us communicate with *you* in confidence by an alternative means or at an alternative location

You may complain to *ADVANTAGE* using the contact information listed at the end of this notice. *You* also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide *you* with the address to file *your* complaint with the U.S. Department of Health and Human Services upon request.

ADVANTAGE supports *your* right to protect the privacy of *your* health information. We will not retaliate in any way if *you* choose to file a complaint with us or the U.S. Department of Health and Human Services. If *you* want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

ADVANTAGE Health Solutions, Inc.SM
 Member Services Department
 9045 River Road, Ste 200
 Indianapolis, IN 46240
 1-800-553-8933
 1-800-743-3333 (TDD for hearing impaired)
 Website: www.advantageplan.com

SECTION 14: ANTI-FRAUD POLICY STATEMENT

ADVANTAGE is committed to the fight against fraud and corruption. *ADVANTAGE* employees, management and Directors refrain from conduct that may violate the fraud and abuse laws. These laws prohibit:

- direct, indirect or disguised payments in exchange for the referral of patients;
- the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and

- making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

Employees, *members*, *providers* and contractors can provide valuable information to alert *ADVANTAGE* to possible fraud and abuse issues. Therefore, *ADVANTAGE* has established reporting mechanisms to ensure timely identification and resolution of issues or suspicions of fraud. We have contracted with FPV, Inc. to establish and manage an external hotline. The hotline will allow employees, *members*, *providers*, and contractors to report suspicion of fraud anonymously or in confidence and without fear of retaliation. Individuals who report problems and concerns in good faith via the hotline will be protected from any form of retaliation. All those who are employed in the external hotline operation are expected to act with utmost discretion and integrity in assuring that information received is acted upon in a reasonable and proper manner. Each FPV employee involved with the *ADVANTAGE* hotline will be required to sign a Confidentiality Agreement.

You may call the *ADVANTAGE* Hotline at **1-888-333-9576**. Our current call center hours are Monday – Friday from 8am – 9pm, and Saturday from 8am – 6pm. During off-hours *ADVANTAGE* has an automated voicemail system and returns all calls on that line.

SECTION 15: GLOSSARY OF TERMS

This section defines terms that have special meanings. The word or phrase is defined in this section or elsewhere in this *Certificate*.

ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE) - Corporation *authorized* to do business in Indiana, licensed under the Indiana Health Maintenance Organization law, which has a *Contract* with *your employer group (Group)* to arrange for health care services for *members* as described in this *Certificate*.

AGREEMENT or GROUP SERVICE AGREEMENT or CONTRACT or GROUP CONTRACT - The *Contract*, including any *amendments* or riders agreed to by *ADVANTAGE* and *your Group* that expresses the rights and obligations of both parties. It also describes the costs, procedures, benefits, conditions, limitations, *non-covered services*, and other obligations to which *members* are subject to under *ADVANTAGE*'s health maintenance organization.

AMBULANCE – A specially designed and equipped vehicle or aircraft that is used for the purpose of responding to *emergency* life-threatening situations and providing *emergency* transportation services. An *ambulance* must be certified as such in the state(s) in which it operates.

ANNUAL BENEFIT MAXIMUM - A maximum number of visits, days, sessions, or specific dollar amount that will be provided per *covered service*, per *member*, and per *calendar year*.

AT HOME POST DELIVERY CARE - Health care services provided to a woman at her residence, including, but not limited to: parent education, assistance and training in breast or bottle feeding; and any maternal and neonatal tests routinely performed during the usual course of *inpatient* care for the woman or her newborn child, including collection of an adequate sample for the hereditary and metabolic newborn screening. Services may be provided by: a *physician*; a *RN*; or an advanced practice nurse whose scope of practice includes providing postpartum care in the area of maternal and child health care. The *At home post delivery care* visit must be provided within 48 hours after the mother and newborn child are discharged from the *hospital*. At the mother's discretion, the visit may occur in the *participating provider's* office.

AUTHORIZATION, AUTHORIZED SERVICES, PRIOR AUTHORIZATION, OR PRE-CERTIFICATION – A *covered service* which has been *authorized* in advance by *ADVANTAGE*.

BEHAVIORAL HEALTH NETWORK - A *participating behavioral health network* of mental health and substance abuse *providers* affiliated with a *member's* assigned *PCP*. The *participating provider network* is responsible for arranging behavioral health services, coordination of care, and case management.

BENEFIT PERIOD – A *benefit period* begins on the first day *you* go to a Medicare-covered *skilled nursing facility*. The *benefit period* ends when *you* have not been an *inpatient* at any *skilled nursing facility* for 60 days in a row. If *you* go to a *skilled nursing facility* after one *benefit period* has ended, a new *benefit period* begins. There is no limit to the number of *benefit periods* *you* can have. The type of care *you* actually receive during the stay determines whether *you* are considered to be an *inpatient* for *skilled nursing facility* stays.

BIOLOGICAL or BIOPHARMACEUTICAL DRUG means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. *Biological or biopharmaceutical products* typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct *physician* involvement, and significant *member* education. These services must be *authorized* by *ADVANTAGE*.

BRAND-NAME (DRUG) means a drug that has been manufactured under a patent and in accordance with the approval for the Food and Drug Administration (FDA).

CARRIER – An underwriter or insurer.

CALENDAR YEAR means the twelve-month period beginning on January 1 and ending on December 31.

CERTIFICATE OF COVERAGE (CERTIFICATE) - The document given to *you*, that describes both *your* and *ADVANTAGE's* rights and duties. It includes the schedule of benefits and any *options*, amendments, riders or attachments to this document.

COINSURANCE and COPAYMENT – The amount a *member* must pay directly to a *participating provider* of *covered services* for those services and supplies. A *member* generally must pay this amount at the time *covered services* are received.

CONTRACT YEAR means the duration of *covered benefits* described in the *Agreement* between *ADVANTAGE* and the *Group* and described on the cover page of this *Certificate*.

COORDINATION OF BENEFITS (COB) - An attempt by one of *ADVANTAGE's participating provider's* and/or *ADVANTAGE* to recover the cost of care provided to a *member* from a third party. The third party may be another insurer, such as automobile, home, business, and/or renter, service plan, government third party payor, or other organization, which also provides *coverage* for a *member's* health care needs. *Coordination of benefits* is subject to any limitations imposed by this *Certificate* or another applicable policy preventing such recovery.

COSMETIC – A service that involves physical appearance, but is not *medically necessary* and does not correct or materially improve a physiological function.

COVERED SERVICES or COVERAGE – Those services or supplies that a *member* is entitled to under this *Certificate*, if the services are *medically necessary* and the *member* has met all other requirements of this *Certificate*. The *Agreement* between *ADVANTAGE* and the *Group*, this *Certificate*, limit what *ADVANTAGE* will pay for some services and supplies. When *ADVANTAGE* says it will “Cover” a service or supply that means *ADVANTAGE* will treat the service as a *covered service*.

CUSTODIAL CARE - Care furnished for the purpose of meeting personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. *Custodial care* is not covered under this *Certificate*.

DEDUCTIBLE - The specific dollar amount of charges for *covered services* that *you* must incur before certain *covered services* will be paid.

DURABLE MEDICAL EQUIPMENT (DME) - Rental or purchase of *DME* is covered only when *medically necessary* and *authorized* by *ADVANTAGE*. *DME* can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of *illness or injury* and is suitable for use in *member's* home. Examples of *DME* include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, *hospital* beds, monitoring devices, oxygen-breathing apparatus and insulin pumps.

EFFECTIVE DATE OF COVERAGE – The date when *your coverage* begins under this *Certificate*.

ELIGIBLE DEPENDENT or DEPENDENT - means a person of the *subscriber's* family: who meets the eligibility requirements of the *Group* and eligibility requirements listed in this *Certificate*; for whom the *subscriber* has applied for membership; and for whom *premiums* have been paid by *Group* and/or *subscriber*. To be an *eligible dependent*, a person must meet *ADVANTAGE's* *service area* requirement, (see *Service Area* definition) and be either: the legal spouse of the *subscriber*; a natural or adopted unmarried *dependent child* of the *subscriber*; other individual determined to be eligible for enrollment by the *Group*; or an unmarried *dependent child* for whom the *subscriber* is the legal guardian or foster parent or has been ordered by a Court or administrative order to provide health care coverage.;

A subscriber and spouse working for the same Group cannot be both subscriber and dependent.

EMERGENCY SERVICES - Services provided due to a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a body organ or part of the individual.

EXPERIMENTAL or INVESTIGATIONAL - Any intervention (treatment, procedure, facility, equipment, drug device, service, or supply): that meets one or more of the following criteria:

- Intervention that is not generally and widely accepted in the practice of medicine in the U.S.; and whose effectiveness is not documented in peer-reviewed articles in medical journals published in the U.S. For interventions to be considered effective, journal articles should indicate that the intervention is more effective than other available, or, if not more effective, is safer or less costly.
- Interventions that are considered *experimental* or *investigational* by:
 - the U.S. Department of Health and Human Services;
 - the National Institute of Health; or

- any of their subsidiary agencies
- Drugs or medical devices *biological* products, or some combination thereof that the U.S. Food and Drug Administration (FDA) has not cleared or approved for commercial distribution, or that do not have other governmental agency approval as required by law.
- Use of an FDA cleared or approved drug, medical device, *biological* product or some combination thereof for a use: (1) that FDA has not cleared or approved and that would otherwise require such clearance or approval (i.e., an ‘off-label’ use); and (2) the effectiveness of which has not been documented in peer-reviewed articles in medical journals published in the U.S. For used of this type to be considered effective, such articles should indicate that using the drug, medical device, biological product, or some combination thereof for he particular use at issue is more effective than other products available for the proposed use, or, if not more effective, is safer or less costly.

FORMULARY - *ADVANTAGE* utilizes a prescription drug *formulary*. A *formulary* is a list of preferred *generic* and *brand name* prescription medications that have been approved by the Food and Drug Administration (FDA).

GENERIC (DRUG) means a copy of a *brand-name drug* for which the patent has expired. The *generic drug* may be of different shape, size, color or flavor, but the active, therapeutic agents are the same as the *brand-name drug*. The same quality and safety standards that apply to *brand-name drugs* also apply to the *generic* form. The FDA sets standards and reviews all *generic* medications before being marketed.

GRIEVANCE is a written or oral complaint submitted in accordance with the formal *grievance* procedure of *ADVANTAGE* by or on behalf of a *member* regarding any aspect of *ADVANTAGE* relative to the *member* that expresses dissatisfaction regarding the:

- Availability, delivery, appropriateness or quality of health care services
- Handling or payment of claims for health care services or;
- Matters pertaining to the contractual relationship between:
 - i) a *member* and *ADVANTAGE*; or
 - ii) a *Group* or individual *Contract* holder and *ADVANTAGE*;
- Any concerns regarding confidentiality of information and for which the *member* has a reasonable expectation that action will be taken to resolve or reconsider the matter that is subject of dissatisfaction.

GROUP means the *subscriber’s* employer who has *contracted* with *ADVANTAGE* to provide *member* and *eligible dependent’s* health benefits.

HEALTH PROFESSIONAL - A professional engaged in the delivery of health services who is licensed, where required, under the laws of the jurisdiction where services are delivered and operating within the scope of his/her license.

HOME HEALTH SERVICES - Health services delivered in a *member’s* home setting and provided by an organization licensed by the State and operating with the scope of its license.

HOSPICE CARE OR FACILITY – a health care facility or a system of professional home visits and supervision, for supportive care of the *terminally ill*.

HOSPITAL - An acute care facility duly licensed in the jurisdiction where services are rendered.

ILLNESS - A sickness or disease and all related conditions and recurrences. The term *illness* includes pregnancy and all related conditions.

INJURY - An accident to the body that requires medical or surgical treatment.

INPATIENT - Confinement as a bed-patient for 24 hours or longer in a *hospital*, *SNF*, or *hospice facility*.

LATE ENROLLEE – As described in this *Certificate*, is a *subscriber* or *eligible dependent* who did not request enrollment with *ADVANTAGE*: during the initial enrollment period in which he/she was first entitled to enroll; or during any special enrollment period, and as described in this *Certificate*.

LICENSED PRACTICAL NURSE - Person who has been licensed by a State Board of Nurse Examiners or other state authority, and how is legally entitled to place the letters “LPN” after his name.

LOW PROTEIN MODIFIED FOOD PRODUCT means a food product that is (1) specially formulated to contain less than one (1) gram of protein per serving; and (2) intended to be used under the direction of a *physician* for dietary treatment of an *inherited metabolic disease*.

MAXIMUM ALLOWABLE AMOUNT – The amount that *ADVANTAGE* determines is the maximum payable for *Covered services* you receive, up to but not exceed charges actually billed. For a non-*participating provider* the *Maximum allowable amount* is the lesser of the actual charge or the standard rate under the contracted used with *participating providers*. The *Maximum allowable amount* is reduced by any penalties for which a *member* is responsible under the terms of this *Certificate*.

MEDICAL FOOD means a food that is (1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by a medical evaluation; and (2) formulated to be consumed or administered internally under the direction of a *physician*.

MEDICALLY or CLINICALLY NECESSARY is defined as:

1. appropriate for the symptoms, diagnosis, or treatment of the medical condition; and
2. provided for the diagnosis or direct care and treatment of the medical condition; and
3. within standards of good medical practice within the organized medical community; and
4. not primarily for the convenience of the member's *physician* or another provider; and
5. not otherwise subject to *non-covered services* under this *Certificate* ; and
6. the most appropriate procedure, supply, equipment, or service that can safely be provided. The most appropriate procedures, supplies, equipment, or service must satisfy the following requirements:
 - i. there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the member with the particular medical condition being treated than other alternatives; and
 - ii. generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - iii. for *hospital* stays, acute care as an *inpatient* is necessary due to the kind of services the member is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an *outpatient* or in a less intensified medical setting

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*.

MEMBER (you, your) - An eligible person enrolled in *ADVANTAGE*'s health plan, as a *subscriber* or *eligible dependent*.

NON-COVERED SERVICES are those services not covered under this *Certificate* and are listed as *non-covered services* in this *Certificate*.

OPEN ENROLLMENT PERIOD - Period of time established by *ADVANTAGE* and the *Group* during which eligible employees and their *eligible dependents* may enroll as new *members*.

OPTION - An addition or amendment to the *Agreement* indicating any additional *covered services* and the corresponding *member copayment*, *coinsurance*, and maximum benefit limits (if applicable).

OUT-OF-POCKET MAXIMUM - Maximum *coinsurance* amount for *covered services*, per *member* and per family per *calendar year*.

OUTPATIENT - Member who receives medical services, but is not an *inpatient*.

PARTIAL HOSPITALIZATION - A structured mental health and/or substance abuse treatment program with sessions of three hours or longer.

PARTICIPATING or CONTRACTING HOSPITAL - A *hospital* that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PHARMACY - A pharmacy or organization of pharmacies that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PHYSICIAN - A *physician* who contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PROVIDER - A *health professional* or other entity that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PCP or PRIMARY CARE PHYSICIAN - A *participating physician* selected by the *member* to be his/her primary health care provider. *Primary care physicians* may include Family or General *Physicians*, Internists, Pediatricians and OB-GYN's.

PHYSICIAN - An appropriately licensed *physician* or surgeon.

PHYSICIAN NETWORK, PROVIDER NETWORK means organized *group* of *physicians*, facilities and *health professionals* contracted with that has entered into a contract with *ADVANTAGE*. A *physician network* has as its primary purpose the delivery, or the arrangement for the delivery, of *covered services*.

POLICY MAXIMUM or CONTRACT MAXIMUM or AGREEMENT MAXIMUM - Total lifetime maximum dollar amount payable for *Covered services* the *member* receives under the *Agreement* issued to the *Group*, including any renewals, endorsements, X9121

amendments or addendums thereto. If there is a lapse in *coverage*, the *policy maximum* applies to all benefits received both before or after the lapse.

PREMIUM – The total payment, including any contributions from *subscribers* or late charges, that the *Group* pays *ADVANTAGE* to maintain *coverage*.

PRE-EXISTING MEDICAL CONDITION – A physical or mental condition for which medical advice, diagnosis, care or treatment is recommended or received up to six (6) months prior to coverage *effective date*. Pregnancy is not considered a *pre-existing medical condition*. Genetic information may not be considered a *pre-existing medical condition* if there is no specific diagnosis of a current disease or medical problem related to the genetic test. A pre-existing medical condition may not apply to a newly born dependent child enrolled within 31 days of date of birth or a dependent child who is adopted by, or placed for adoption with, the subscriber and enrolled within the first 31 days of placement with the subscriber or within 31 days of the date of entry of the order granting the adopting parent custody of the child for purposes of adoption.

PRE-EXISTING MEDICAL CONDITION EXCLUSION PERIOD – The period of time during which services relating to *pre-existing medical conditions* are not considered *covered services* under this *Certificate*. The *pre-existing exclusion period* is six (6) months from the effective date of coverage with *ADVANTAGE*, less the number of months exhausted under *prior creditable coverage*.

PRIOR CREDITABLE COVERAGE – *Creditable coverage* you had prior to your *effective date* with *ADVANTAGE* that was continuous. For the purpose of this section, “continuous” means *coverage* that was not interrupted by a break of 63 or more days in a row. There can be more than one break, but no single break can be 63 or more days in length. Proof of *prior creditable coverage* is determined by a Certificate of *Creditable Coverage*, which is a written Certificate of *your prior coverage* provided to you by your prior health *carrier*. The *Certificate* must identify you as the covered person, period of *coverage*, and waiting periods (if any).

PROPER REFERRALS - Process where a *member’s physician* directs the *member* to seek or obtain *covered services* from another *participating or non-participating health professional* or *inpatient facility* subject to *ADVANTAGE’s pre-certification* requirements.

PROVIDER - Any *hospital, physician, pharmacy, SNF, individual, organization, or agency* that is licensed to provide professional services within the scope of that license or certification.

PROVIDER DIRECTORY – A document listing *ADVANTAGE’s participating providers* available to you under this *Certificate*.

QUALITY IMPROVEMENT (“QI”) COMMITTEE - Committee of *physicians and other health professionals* selected and approved by the *provider network* and/or *medical Group* to disseminate and maintain professional standards.

REGISTERED NURSE (RN) - A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters “RN” after his name.

RENEWAL DATE - Date on which the *Agreement* will be renewed.

SECOND OPINION - Medical or surgical opinion that is provided by a *physician*, to reevaluate the condition. The *second opinion* is made with prior *authorization* from *ADVANTAGE*.

SERVICE AREA means the geographical area where the *member* must work or reside to be eligible to enroll, which is **30 air miles** of the office of the *member’s assigned PCP*.

SKILLED NURSING FACILITY or SNF - Institution, or a distinct part of an institution, which:

- is duly licensed in the state of Indiana; is regularly engaged in providing 24-hour skilled care under the regular supervision of a *physician* and the direct supervision of a *RN*;
- maintains a daily record on each patient; and
- provides each patient with active treatment of an *illness or injury*, or related rehabilitation, in accordance with existing standards of medical practice for that condition.

A *SNF* does not include any institution or portion of any institution that is primarily for rest, the aged, non-skilled care, or care of mental diseases or substance abuse.

SPECIALTY CARE PHYSICIAN (SCP) - A *physician* who has an identified specialty other than a family practice, internal medicine, or pediatrics; and who is not acting in the role of a *PCP* to the *member* at the time services are provided. Examples of *SCPs* would include surgeons (orthopedic, cardiovascular, vascular, etc.), cardiologists, oncologists, urologists, etc.

SPOUSE - *Subscriber’s legal spouse*.

SUBSCRIBER (you, your) - An employee of the *Group*, who resides and/or works in Indiana (the geographic area in which *ADVANTAGE* is licensed), who meets the eligibility requirements of the *Group*, who has enrolled for coverage with *ADVANTAGE*, and for whom *premiums* have been paid by the *Group*. A *subscriber* and *spouse* working for the same *Group* cannot be both *member* and *dependent*.

TERMINALLY ILL OR TERMINAL ILLNESS - A *physician* has given a prognosis that a *member* has six months or less to live.

URGENT CARE - Urgently needed services or *urgent care* services are instances when a *member* needs *covered services* urgently:

- to prevent serious deterioration of health;
- resulting from an unforeseen *illness* or *injury*;
- while outside of the *service area*;
- for which treatment cannot be delayed until the *member* returns to the *service area* without the *member's* condition growing much worse.

Urgently needed services are determined by medical condition not the place of treatment.

WELL CHILD CARE - A clinical check of a child for the purpose of assessing physical status and detecting abnormalities, in the absence of symptoms. *Well child care* includes pediatric immunizations including, but not limited to: diphtheria, pertusis, small pox, measles, mumps, rubella, poliomyelitis, and tetanus.

WOMAN AT RISK - A woman who meets at least one of the following descriptions:

- a woman who has personal history of breast cancer;
- a woman who has a personal history of breast disease that was proven benign by biopsy;
- a woman whose mother, sister, or daughter has had breast cancer; or

YOU or YOUR or MEMBER - An *eligible person* enrolled in *ADVANTAGE's* health plan, as a *subscriber* or *eligible dependent*.

YOUNG ADULT – means a person who, regardless of marital status:

- (1) between the ages of 19 and 24; and
- (2) is not eligible for coverage as an eligible dependent under the subscriber contract; and
- (3) meets one of the following criteria:
 - (A) is the natural or adopted child of a subscriber; or
 - (B) is the stepchild, grandchild, other blood relative of a subscriber and the subscriber pays more than 50% of the person's total support; or
 - (C) the subscriber is the persons' legal guardian and the subscriber pays more than 50% of the person's total support.

Family Planning Services Rider

The Certificate is amended as follows. If there is any conflict between the Certificate and this Rider, this Rider shall prevail. The effective date of this Rider is the date shown on the Contract.

Ethical and Religious Directives: ADVANTAGE Health Solutions, Inc.sm (ADVANTAGE) is an institution operated in accordance with The Ethical and Religious Directives for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. ADVANTAGE shall not be required to provide, and no provision of a Policy shall be construed so as to require it to provide, services that are inconsistent with the medical ethics or precepts of the Catholic Church.

Family Planning Services means:

1. birth control drugs that require a prescription
2. birth control devices that require a prescription, including the removal of such devices; and
3. voluntary sterilization

FAMILY PLANNING SERVICES

ADVANTAGE is owned by Catholic organizations. Because of this, ADVANTAGE cannot provide services that are not in accord with the Ethical and Religious Directives. Coverage for Family Planning services will be provided and claims will be administered through a 100% reinsurance program through:

Cyrca Insurance Management
303 Congressional Blvd.
Carmel, IN 46032
1-800-510-0225

50% coinsurance up to \$2,500 lifetime maximum for all Family Planning Services except for prescription drugs for birth control. Prescription drugs for birth control are excluded from the lifetime maximum. The applicable copayment for prescription drugs for birth control is equal to the amount of the outpatient prescription drug copayment stated in the Certificate if member is entitled to pharmacy benefits.

EXCLUSIONS

1. Abortion, except when the life of the mother would be endangered if the fetus were carried to term.
2. Birth control drugs or devices that do not require a prescription. For example:
 - a. condoms; and
 - b. foams, jellies, or creams used to kill sperm.
3. Oral and injectable drugs which are used primarily for the purpose of treating infertility. (For example, Clomid, Metrodin, and Pergonal.)
4. Cryopreservation of ova, sperm, or fertilized eggs.
5. Any procedure which involves destroying human embryos.
6. Artificial insemination, except by the covered person's spouse.
7. Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), or in-vitro or in-vivo fertilization.
8. Use of a surrogate for any reason.

9. Treatment for infertility.

10. Oral drugs for the treatment of impotence.