

Virginia Private Colleges Benefits Consortium, Inc.

**Health Plan Document
and
Summary Plan Description**

HMO POS Open Access Plans 8 - 11

**Amended and Restated Effective
January 1, 2022**

Virginia Private Colleges Benefits Consortium, Inc.
Health Plan Document
HMO/POS Open Access Plans 8 - 11
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Section 1 Introduction

1.1 Introduction

The Virginia Private Colleges Benefits Consortium, Inc. Health Plan (the “Plan”) shall be effective January 1, 2022. The Plan may be amended at any time, in whole or in part, by the Board of Directors.

The Plan has been approved by the Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc. (“VPC Benefits Consortium”). The Plan is intended to meet the requirements of the Employee Retirement Income Security Act of 1974 (“ERISA”), and Section 501(c)(9) of the Internal Revenue Code of 1986 (“Code”) and the Regulations promulgated thereunder, as amended from time to time (“Section 501(c)(9)”). The VPC Benefits Consortium is authorized by Section 23.1-106 of the Code of Virginia, which allows certain institutions of higher education in the Commonwealth of Virginia to form a higher education benefits consortium.

This document and any amendments constitute the governing document of the Plan. This Plan is a multiple employer plan, designed and administered exclusively for the Members of the VPC Benefits Consortium. Employees are entitled to this coverage if the provisions in the Plan have been satisfied. This Plan is void if Participant ceases to be entitled to coverage. No clerical error shall invalidate such coverage if otherwise validly in force.

The Board of Directors intends to maintain the Plan indefinitely. However, the Board of Directors has the right to modify the Plan at any time, and for any reason, as to any part or in its entirety, without advance notice. Likewise, the Board of Directors has the right to terminate the Plan at any time, and for any reason, upon 90 days’ notice to the Members. If the Plan is amended or terminated, the Participant may not receive benefits described in the Plan after the Effective Date of such amendment or termination. Any such amendment or termination shall not affect Participant’s right to benefits for claims incurred prior to such amendment or termination. If the Plan is amended, a Participant may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA benefits. This may happen at any time. If this Plan is terminated, the Participant will not be entitled to any vested rights under the Plan.

Anthem Blue Cross and Blue Shield (“Anthem HealthKeepers” or “HealthKeepers”) is the Claims Administrator under the Plan. Anthem HealthKeepers does not serve as an insurer, but merely as a claims processor.

Important phone numbers

Anthem HealthKeepers Member Services

833-597-2358

IngenioRx Pharmacy Member Services

833-389-1968

Tim Klopfenstein – Executive Director

Virginia Private Colleges Benefits Consortium, Inc.

540-586-1803

How to obtain language assistance

HealthKeepers is committed to communicating with our Members about their health Plan, regardless of their language. HealthKeepers employs a Language Line interpretation service for use by all of our Member Services Call Centers. Simply call the Member Services phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If *you* need Spanish-language assistance to understand this document, *you* may request it at no additional cost by calling the customer service number.)

Hours of operation:

Monday – Friday

8:00 a.m. to 6:00 p.m.

Saturday

9:00 a.m. to 1:00 p.m.

24/7 NurseLine (Medical Questions and Future Moms)

800-337-4770

Advice on Reading this Document. Some of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this Document or in other relevant Sections. Becoming familiar with the terms defined in the Glossary will give Participant a better understanding of the procedures and benefits described.

Summary Plan Description. This Plan Document and the associated Summaries of Benefits and Coverage (hereinafter “SBCs”) constitute the Plan Document and Summary Plan Description required by ERISA Section 102. Should the terms of this Plan Document and Summary Plan Description conflict with the terms of the associated SBCs the terms of the associated SBCs will control, unless superseded by applicable law.

Section 2
Plan Identifying Information

Name of the Plan	Virginia Private Colleges Benefits Consortium, Inc. Health Plan (the “Plan”)
Type of Plan	Health and Welfare Plan
Funding Medium and Type of Plan Administration	<p>Anthem Blue Cross and Blue Shield (“Anthem”) is the Medical Claims Administrator under the Plan. IngenioRx provides Pharmacy Benefit Management services. IngenioRx does not serve as an insurer, but merely as claims processor. The address of Anthem Blue Cross and Blue Shield is: P.O. Box 27401, Richmond, VA 23279. The address of IngenioRx is: PO Box 52065, Phoenix, AZ 85072.</p> <p>The VPC Benefits Consortium receives contributions from Members and Participants, and holds those assets in trust for the exclusive benefit of Participants and Dependents. Claims are paid out of these assets.</p> <p>To further protect the Plan from catastrophic losses, the Consortium has purchased excess liability insurance in the form of a stop-loss insurance policy.</p>
Address of Plan	<p>Virginia Private Colleges Benefits Consortium, Inc. 118 East Main Street P.O. Box 1005 Bedford, VA 24523 (540) 586-1803</p>
Plan Administrator and Agent for Service of Legal Process	<p>Tim Klopfenstein Virginia Private Colleges Benefits Consortium, Inc. 118 East Main Street P.O. Box 1005 Bedford, VA 24523 (540) 586-1803</p>
Plan Number	501
Plan Sponsor and its IRS Employer Identification Number	<p>Virginia Private Colleges Benefits Consortium, Inc. EIN: 27-1367957</p>
Plan Effective Date	January 1, 2010
Amended and Restated Effective Date	January 1, 2022
Plan Renewal Date	January 1 st
Plan Year End	December 31 st

Named Fiduciary The Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc.

Preauthorization Providers Anthem Blue Cross and Blue Shield
IngenioRx

Board of Directors

President: Ken Copeland
Vice-President: Don Aungst
Secretary: Kim Harper
Treasurer: Holli Harman
Executive Director: Tim Klopfenstein

Section 3 How Your Coverage Works

3.1 Your Coverage

Your coverage provides a wide range of health care services. The information contained in this section is designed to help you understand how you can access your benefits. For more specific information on Copayments, Coinsurance and benefit limits, please refer to the associated SBCs.

3.2 Carry Your Identification (“ID”) Card

Your coverage ID card(s) identifies you as a Covered Person and contains important health care coverage information. All Participants will receive an Anthem ID card.

Carrying your card at all times will ensure you always have access to this coverage information with you when you need it. Make sure you show your ID card to your Doctor, Hospital, or other health care provider so they know you’re an Anthem HealthKeepers Covered Person. HMO Providers have agreed to submit claims to us on your behalf. In addition, make sure you show your card to your pharmacist.

3.3 Primary Care Physicians (“PCP”)

Your PCP will provide your primary health care services such as annual physicals and medical tests, oversee care when you are ill or injured, and treat any chronic health problems or diseases. You should establish a personal and continuous relationship with your PCP. Building and maintaining this ongoing relationship is an important part of health care.

Your coverage does not require that you obtain a referral from your PCP to receive care from other HMO Providers. However, you may want to let your PCP know about other HMO Providers that are treating you so that your PCP can better oversee your health care.

3.4 Out-of-Plan Benefits

Your Plan provides Out-of-Plan Benefits, as set forth in the associated SBCs. Out-of-Plan Benefits are benefits for services received from a non-HMO Provider. For non-Emergency Inpatient admissions, Out-of-Plan Benefits will only be available if you initiate pre-admission authorization from the HMO, as further explained in the “Preauthorization Process” and “Hospital Admissions” sections of this Plan Document. Please contact Member Services with questions concerning Out-of-Plan Benefits.

3.5 The Preauthorization Process

The HMO will make coverage decisions on services requiring Preauthorization within 15 days from the receipt of the request. The HMO may extend this period for another 15 days if the HMO determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 15-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, the HMO will make its decision within 2 working days of its receipt of the medical information needed to process the Preauthorization request.

Prescription Drugs. Preauthorization may be required for certain prescription drugs in order to determine coverage. If the Participant does not obtain a Preauthorization, or if the Preauthorization is denied, a prescription drug may not be covered, or it may be at a higher cost to the Participant.

As a part of the Preauthorization process for certain prescription oncology drugs, limited genetic testing may be performed in order to determine the likelihood that a prescribed medication will be effective based on the

individual's unique genetic makeup. If the Participant does not undergo the genetic testing, or if the Preauthorization is denied, a prescription drug may not be covered, or it may be at a higher cost to the Participant.

Urgent Care Visits. For Urgent Care Claims, coverage decisions will be completed and we will respond to you and your provider as soon as possible taking into account your medical condition, but not later than 72 hours from receipt of the request. If insufficient information is submitted in order to review the claim, we will ask you or your provider for the information needed within 24 hours of the receipt of your request. The Participant's Doctor will be notified verbally of the coverage decision within 48 hours of receiving the information. If the requested information is not received within 48 hours of our request, we will make our decision within 96 hours from the date of our request. In cases where a Hospital admission is an Urgent Care Claim, a coverage decision will be completed within 24 hours. Your Physician will be notified verbally of the coverage decision within this timeframe.

Once the HMO has made a coverage decision on services requiring Preauthorization, you will receive written notification of the coverage decision. In the event of an Adverse Benefit Determination, the written notification will include the following:

- Information sufficient to identify the claim involved;
- The specific reason(s) and the Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- A description of the HMO's appeal procedures and applicable time limits;
- In the case of an Urgent Care Claim, a description of the expedited appeal and expedited review process applicable to such claims; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you with the internal or external appeals process.

If all or part of a Pre-Service or Urgent Care Claim was not covered, you have a right to see upon request and at no charge, any rule, guideline, protocol or criterion that the HMO relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition. Please see Section 12 for additional information.

3.6 Approvals of Care Involving an Ongoing Course of Treatment/Concurrent Care

HMO Providers must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If you are receiving care from a non-HMO Provider and need to receive an extension of a previously approved course of treatment, you will be required to ask for the extension. You should request the extension at least 24 hours prior to the end of the authorized timeframe to avoid disruption of care or services. We will notify you of our coverage decision within 24 hours of your request.

If we make a determination to reduce or terminate benefits for all or any part of a previously approved course of treatment prior to its conclusion, this will be considered an Adverse Benefit Determination. If the reduction or termination was not a result of a health Plan amendment or health Plan termination, we will notify you in advance of the reduction or termination in sufficient time for you to file an internal appeal prior to the reduction or termination. Additional information relating to Ongoing Course of Treatment/ Concurrent Care Claims is found in Section 12, Claims and Payments.

3.7 Non-HMO Providers

In the event that you receive Covered Services from a non-HMO Provider, we reserve the right to make payment of such Covered Services directly to you, the non-HMO Provider, or any other person responsible for paying the non-HMO Provider's charge. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the non-HMO Provider. If you receive services from a non-HMO Provider without the proper authorization, you will receive Out-of-Plan Benefits. In addition, you may be responsible for any charges over our Maximum Allowed Amount and this amount will not apply toward your annual Copayment limit.

3.8 Terminated Providers

The HMO Network is subject to change as health care providers are added to the Network, move, retire, or change their status. When providers decide to leave the Network, they become non-Participating Providers, and services, unless properly authorized, will not be covered.

There are three instances when Covered Persons may continue seeing providers who have left the Network.

- A Covered Person in the second or third trimester of pregnancy may continue seeing her obstetrician-gynecologist through postpartum care for that delivery.
- Covered Persons with life expectancy of six months or less may continue seeing their treating Physician.
- You have chosen to receive services on an Out-of-Plan basis.

3.9 Guest Memberships

When you or any of your dependents will be staying temporarily outside of the Service Area for more than 90 days, you can request a guest membership to a Blue Cross and Blue Shield affiliated HMO in that area. An example of when this service may be utilized is when a Dependent student attends a school outside of the Service Area. Call a Member Services representative at 833-597-2358 to make sure that the area in which you or your dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated HMO plans. If the area is within the Network, you will need to complete a guest membership application and you will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield HMO affiliate where you or your covered dependents will be staying. Member Services will explain any limitations or restrictions to this benefit. If you are staying in an area that is not within the Guest Membership Network, this service will not be available.

Certain Anthem HealthKeepers plans qualify as high Deductible health plans which allow a Participant to contribute to a health savings account on a pre-tax basis. To maintain the ability to contribute to such an account, one of the requirements is that a Participant may not also be enrolled in other health plan coverage that is not a qualifying high Deductible health plan.

If you are enrolling in Guest Membership, keep in mind that the other plan membership may not qualify as a high Deductible health plan. If you think this provision may apply, please consult your tax advisor as to the impact your enrollment in Guest Membership may have on your health savings account.

3.10 The Difference Between Emergency Care and Urgent Care

An Emergency is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including severe pain that, without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:

- Serious jeopardy to the mental or physical health of the individual;

- Danger of serious impairment of the individual’s body functions;
- Serious dysfunction of any of the individual’s bodily organs; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Urgent Care Situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury. Examples of Urgent Care Situations include high fever, vomiting, sprains or minor cuts.

Helpful tip: If you cannot contact your PCP or are unsure if your condition requires Emergency or urgent care, the 24/7 NurseLine is available to help you 7 days a week. A registered nurse will discuss your symptoms with you and recommend an appropriate level of care.

3.11 When You Need to Access Health Care (within the Service Area)

- Medical Care is available through your PCP 7 days a week, 24 hours a day. If you need care after regular office hours you may contact the on-call PCP or the 24/7 NurseLine. For instructions on how to receive care, call your PCP or the 24/7 NurseLine at 800-337-4770.
- If your condition is an Emergency, you should be taken to the nearest appropriate medical facility.
- Your coverage includes benefits for services rendered by providers other than HealthKeepers providers when the condition treated is an Emergency as defined in this Plan Document.

3.12 When You are Away From Home (outside the Service Area) and Need to Access Care

HealthKeepers does business only within a certain geographic area in the Commonwealth of Virginia. See The BlueCard Program below for Covered Services received outside of Virginia. Services outside the Service Area are provided to help you if you are injured or become ill while temporarily away from the Service Area. In order to receive in-plan benefits for these services, you must satisfy any authorization requirements outlined in this Plan Document and obtain care from a health care provider that has a contractual arrangement with the local Blue Cross and/or Blue Shield licensee in the area where you are being treated. The BlueCard Program section provides additional details and you may locate a contracting provider by visiting www.anthem.com or calling Member Services.

If you need to access care when you are temporarily outside the Service Area:

- You should obtain care at the nearest medical facility if you have an Emergency or urgent care situation;
- You will be responsible for payment of charges at the time of your visit; and
- You should obtain a copy of the complete itemized bill for filing a claim with HealthKeepers. For more information on filing claims see the Claims and Payments section of the Plan Document.

3.13 Out-of-Area Services

HealthKeepers has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Arrangements.” These Inter-Plan Arrangements are subject to the rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever you obtain healthcare services outside HealthKeepers’ Service Area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which include the BlueCard Program and may include negotiated National Account arrangements available between HealthKeepers and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside HealthKeepers' Service Area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare Providers. HealthKeepers' payment practices in both instances are described below. Most claims are eligible to be processed through Inter-Plan Arrangements, except for prescription drugs that are obtained from a pharmacy and most dental or vision benefits.

3.14 The BlueCard® Program and Negotiated Arrangements for National Accounts

Under the BlueCard® Program, when you obtain Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, HealthKeepers will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers. For certain Host Blues, instead of using the BlueCard Program, claims may be processed through negotiated arrangements for National Accounts.

Whenever you access covered health care services outside the HealthKeepers Service Area and the claim is processed through the BlueCard Program, or through a negotiated National Account Arrangement, the amount you pay for covered health care services, if not a flat dollar Copayment, is calculated based on the lower of:

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

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

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

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

If covered health care services are received under a value-based program inside of a Host Blue's service area, you are not responsible for paying any of the provider incentives, risk-sharing, and/or case coordinator fees that are a part of such an arrangement, except where a Host Blue passes these fees to HealthKeepers through average pricing or fee schedule adjustments.

Please refer to the Claims and payments section of this Plan Document for information on Non-Participating Providers and facilities.

Non-participating health care providers outside the Plan's Service Area

Member Liability Calculation. When covered health care services are provided outside of the Plan Service Area by non-participating health care providers, the amount the Participant pays for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state or federal law. In these situations, the Participant may be liable for the difference between the amount that the non-participating health care provider bills and the payment the Plan will make for

the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

3.15 Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your group or call customer service at the number on your identification card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the customer service number on your identification card for coverage details.
- Always carry your up to date HealthKeepers identification card.
- In an Emergency, go straight to the nearest Hospital. There is no need to call before you receive care.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at (800) 810-2583 or by calling collect at (804) 673-1177. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-Emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient Care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your identification card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- Participating BlueCard Worldwide Hospitals. In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient Care at participating BlueCard Worldwide Hospitals except for the Out-of-Pocket Costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- Doctors and/or non-participating Hospitals. You will need to pay upfront for Outpatient services, care received from a Doctor, and Inpatient Care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- In most cases, the Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the Out-of-Pocket Costs you normally pay.
- You must file the claim for Outpatient and Doctor care, or Inpatient Care not arranged through the BlueCard Worldwide Service Center. You will need to pay the provider and subsequently send an International claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at www.bcbsglobalcore.com. The address for sending in claims is on the form.

3.16 Notification

The HMO will participate in coordinating your care if you are Hospitalized as a result of receiving Emergency Services. You or a representative on your behalf should notify the HMO within 48 hours after you begin receiving care. This applies to services received within or outside the Service Area.

3.17 Hospital Admissions

All non-Emergency Hospital admissions must be arranged by the Covered Person's admitting HMO Physician and approved in advance by the HMO, except for maternity admissions as specified in the maternity section of this Plan Document. We also reserve the right to determine whether the continuation of any Hospital admission is Medically Necessary. For Emergency admissions, refer to the preceding paragraph Notification.

The HMO will respond to a request for Hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. The HMO may extend this period for another 15 days if the HMO determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

In cases where the Hospital admission is an Urgent Care Claim, a coverage decision will be completed within 24 hours. Your Physician will be notified verbally of the coverage decision within this timeframe.

Once a coverage decision has been made regarding your Hospital admission, you will receive written notification of the coverage decision. In the event of an Adverse Benefit Determination, the written notification will include the following:

- Information sufficient to identify the claim involved;
- The specific reason(s) and the Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- A description of the HMO's appeal procedures and applicable time limits;
- In the case of an Urgent Care Claim, a description of the expedited review process applicable to such claims; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you with the internal or external appeals process.

If all or part of a Hospital admission was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the HMO relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive upon request, and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to your medical condition. Please see Section 12 for additional information.

Hospital admissions for covered radical or modified radical mastectomy shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours. Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

For an uncomplicated vaginal delivery, this Plan will cover a 48-hour Hospital stay. For an uncomplicated cesarean delivery, the Plan will cover a 96-hour Hospital stay. If a decision is made to discharge a mother or newborn before the expiration of the minimum hours, listed above, coverage is provided for timely post-delivery care by a Doctor, Midwife, Registered Nurse, or other appropriate licensed health care provider and may be provided at the mother's home, a health care provider's office, or a Health Care Facility.

Out-of-Plan

You must initiate the Preauthorization process from the HMO if you choose to receive Out-of-Plan care for non-Emergency Inpatient admissions including admissions for mental health and Substance Use Disorder conditions. If authorization is not received from the HMO, you will be responsible for all costs (Physician, non-Physician, and facility) related to the Hospital stay.

3.18 If You Changed Coverage Within the Year

Your health Plan may include Calendar Year limitations on Deductibles, Out-of-Pocket Expenses, or benefits. These limitations may be affected by a change of health Plan coverage during the Calendar Year.

- If you change from one Employer's health Plan to another Employer's health Plan during the Calendar Year, new benefit limitations and Out-of-Pocket Amounts will apply as of your Effective Date of coverage under the new Employer's health Plan. Amounts that may have accumulated toward specific benefits or Out-of-Pocket Amounts under your former Employer's health Plan will not count under your new Employer's health Plan.
- If you do not change Employers, but move from coverage other than Anthem HealthKeepers coverage (issued by any Anthem-affiliated HMO) to Anthem HealthKeepers coverage during the Calendar Year, new benefit limitations and Out-of-Pocket Amounts will apply as of the Effective Date of your Anthem HealthKeepers coverage. Amounts that may have accumulated toward specific benefits or Out-of-Pocket Amounts under the other coverage will not count under the Anthem HealthKeepers coverage.
- If you do not change Employers, but move from one Anthem HealthKeepers benefit Plan or option to another Anthem HealthKeepers benefit Plan or option during the Calendar Year, any amounts that had accumulated toward the Calendar Year benefit limitations and Out-of-Pocket Amounts before the change will count under the new Anthem HealthKeepers benefit Plan or option for the remainder of the Calendar Year.

Section 4 Enrollment and Contributions

4.1 Participant Enrollment

The “Effective Date” for the Employees of a Member shall be the first day of the month following or coinciding with the Employee’s date of hire, provided that:

- **Enrollment.** The Employee meets the requirements for eligibility and properly enrolls in the Plan no later than 31 days following the Employee’s date of hire;
 - Continuously meets the requirements for eligibility; and
- **Contributions.** The Member, Employee or Part Time Employee makes the required Contributions toward the cost of coverage for the Participant and any Covered Dependent(s). The formula used for allocating the required Contributions between the Member and its Employees must be approved by the Board of Directors. The amount of the respective Contributions shall be set forth in notices from the Plan Administrator and may be changed from time to time by the Board of Directors.

4.2 Dependent Enrollment

- **Initial Enrollment.** If the Dependent satisfies the definition of a “Dependent” in the Glossary and if a Participant properly enrolls the Dependent within 31 days of the date of hire, the Dependent’s Effective Date shall be the same day as the Participant’s Effective Date. A Disabled Child must meet the definition of a Disabled Child and satisfy the requirements for Initial Enrollment of a Disabled Child, both contained in the Glossary.
- **Later-Acquired Dependent.** If a Participant, after initial enrollment, acquires a new eligible Dependent, the Participant may complete, sign and return an application to the Plan Administrator within the period set forth below. If the newly acquired Dependents are enrolled within this period, the Effective Date of that Dependent’s coverage is the first date in which the Dependent met the definition of Dependent.
 - **Newborn or Adopted Children (Special Enrollees).** Newborn and newly adopted children shall be covered for Injury or Illness from the moment of birth, adoption, or placement for adoption. Covered Services include the necessary care or treatment of medically diagnosed Congenital Defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent within **60 days** of the child’s date of birth, adoption or placement for adoption. This provision shall not apply to or in any way affect the maternity coverage applicable to the mother.

Actual Enrollment Necessary Upon Birth of Newborn, Adoption or Placement for Adoption. It is necessary to obtain, complete, sign and return a **new enrollment form** to add a newborn or adopted child to the Plan. If the Participant fails to complete, sign and return an enrollment form within **60 days** after birth of a newborn, adoption or placement of adoption, the Dependent **will not have coverage** or be able to enroll until the next Open Enrollment period. Claims for maternity expenses or maternity leave **do not** constitute notification or enrollment of a new Dependent for coverage.

- **Siblings and Other Dependents Upon Birth or Adoption (Special Enrollee).** If a Participant’s other Dependents are not Covered Persons, the Participant may enroll these other Dependents along with a newborn or adopted child as described in the subsection above. If the Participant enrolls the other Dependents within **60 days**, the Special Enrollment Date and coverage shall become effective on the child’s date of birth, adoption, or upon placement for adoption.

- **Spouse Upon Marriage (Special Enrollee).** A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent within **31 days** of the date of marriage.
- **Court Order or Decree.** If a Dependent is acquired through a court order, decree, or marriage, that Dependent will be considered a Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled within **31 days** of the court order, decree, or marriage.
- **Qualified Medical Child Support Order.** A child may become eligible for coverage as set forth in a Qualified Medical Child Support Order. The Plan Administrator will establish written procedures for determining (and have sole discretion to determine) whether a medical child support order is qualified and for administering the provisions of benefits under the Plan pursuant to a Qualified Medical Child Support Order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.
- **Dependent Contributions.** A Participant or Dependent may be required to make periodic contributions toward the cost of the Dependent's coverage under the Plan in an amount determined by the Plan Administrator. The amount of the respective contributions shall be set forth in notices from the Plan Administrator, and may be changed from time to time by the Board of Directors.

4.3 Loss of Alternate Health Coverage (Special Enrollees)

A Participant or a Dependent who was previously eligible for coverage, but did not enroll because of alternate health coverage, may complete, sign and return an application to the Plan Administrator within the **31-day** Special Enrollment Period following the Participant or Dependent's loss of such other coverage (including coverage through the Marketplace) due to any of the following:

- Exhaustion of COBRA Continuation Coverage;
- Loss of eligibility for such other coverage due to divorce, legal separation, death, Termination of Employment or reduction of hours of employment;
- Termination of Employer contributions; or
- Reaching the lifetime limit on all benefits under the Eligible Employee's or Dependent's prior plan.

For a Disabled Child only, a significant cost increase of the Disabled Child's coverage through the Marketplace will constitute a loss of coverage and thus a special enrollment right for the Disabled Child, provided that the child meets the definition of a Disabled Child and satisfies the requirements for Special Enrollment of a Disabled Child, both contained in the Glossary.

Individuals who lose coverage due to nonpayment of premiums or for cause (e.g. filing fraudulent claims) shall not be Special Enrollees hereunder.

Coverage for a Special Enrollee hereunder shall begin as of the day following loss of alternate health coverage, but not more than 31 days prior to the date the enrollment application is received by the Plan Administrator.

4.4 Special Enrollment Based on Children's Health Insurance Program (CHIP)

Employees and Dependents who are eligible but not enrolled for coverage when initially eligible may become a Special Enrollee in two additional circumstances:

- The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or

- The Employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

4.5 Change in Status

The Plan allows elections changes outside of Open Enrollment based on certain change in status events. The cafeteria plan of the Member governs whether a corresponding mid-year change is allowed to a Participant's pre-tax salary reduction election. Participants should refer to the Member's plan document governing the cafeteria plan to determine whether pre-tax salary reduction elections can be changed for the following change in status events allowed under this plan:

- When a change in contribution is significant, a Participant may either increase the contributions or change to a less costly coverage election.
- When a new benefit option is added, a Participant may change to elect the new benefit option.
- When a significant overall reduction is made to a benefit option, a Participant may elect another available benefit option.
- A Participant may make a coverage election change if the Spouse or Dependent is covered as an Employee or Dependent under another employer plan and that plan incurs a change such as adding or deleting a benefit option and:
 - The other employer plan allows a permitted mid-year election change; or
 - The other employer plan allows election changes due to its annual Open Enrollment period not coinciding with this Plan's annual Open Enrollment period.

4.6 Participant's and Dependent's Termination of Participation

A Participant and Dependent's participation under the Plan shall terminate on the earlier of the following occurrences:

- The end of the month in which the Participant Terminates Employment with a Member; unless the Member is obligated to continue to make contributions on behalf of such Participant by terms of the employment agreement between the Member and the Participant including the Member's personnel manual;
- The end of the month in which the Participant loses his status as a Participant, or the Dependent loses his status as a Covered Dependent;
- The Plan terminates;
- While on an Approved Leave of Absence or Approved Sabbatical, the Participant becomes employed full time by another employer and is eligible for health benefits;
- The failure to pay required contributions. In such case coverage shall terminate on the last date for which the required contributions were paid, as determined by the Plan Administrator;
- Upon a Participant's death, any Covered Dependent may remain a Dependent for the applicable period of Continuation Coverage set forth in the Continuation of Coverage Section, provided that the Covered Dependent complies with the conditions therein; or
- For cause (i.e. fraudulent claims).

If the Participant's coverage is terminated for cause, the coverage for all Dependents is terminated as well. Eligibility for other insurance coverage must be determined by the Members if the HMO's coverage is terminated for cause. The conditions under which your HMO coverage may be terminated for cause are as follows:

- o If you allow someone to use your identification card or you use another Covered Person's card, the HMO may recall the card and terminate your coverage upon 31 days written notice.
- o You represent that all information contained in applications, questionnaires, forms, or statements submitted to the HMO is true, correct, and complete, and if you furnished incorrect or incomplete information which constitutes a material misrepresentation, then your coverage may be terminated upon written notice. Covered Persons terminated for this reason will be responsible to pay charges for all services provided to the Covered Person that are related to this incorrect or incomplete information.
- o If you are guilty of fraud, gross or repeated misbehavior, including but not limited to, abusive behavior to HMO Providers and the HMO administrative personnel in applying for or seeking any benefits under this Plan, then the HMO may terminate your coverage upon 31 days written notice.
- o When, after reasonable efforts (including changing Physicians), you cannot establish or maintain a satisfactory Physician-patient relationship with your PCP, the HMO may terminate your coverage upon 31 days written notice. Evidence of an unsatisfactory Physician-patient relationship may include your refusal to accept procedures or treatment recommended by your PCP. When an HMO Physician regards such refusal as incompatible with the continuance of the Physician-patient relationship and as obstructing the provision of proper Medical Care, the HMO may terminate your coverage and disclaim all financial responsibility for any further Covered Service costs incurred by you.

4.7 Rescission of Coverage

The Plan Administrator reserves the right to rescind coverage under the Plan if an Employee, spouse or child becomes covered under this Plan or receives Plan benefits as a result of an act, practice or omission that constitute fraud or is due to the intentional misrepresentation of a material fact, both of which are prohibited by this Plan. Rescission is a cancellation and discontinuance of coverage, retroactive to the date the Employee, spouse or child became covered or received a Plan benefit as a result of fraud or the intentional misrepresentation of a material fact. The Plan Administrator will provide at least 30 days advance notice to an Employee, spouse or child of its intent to rescind coverage with an explanation of the reason for the intended rescission. The rescission shall not apply to benefits paid more than one year before the date of such advance notice. A cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage only has a prospective effect;
- the cancellation or discontinuance of coverage is only retroactive to the extent it is attributable to the timely failure to pay Premiums (including COBRA Premiums) toward the cost of coverage; or
- the cancellation or discontinuance of coverage is initiated by the Employee, spouse or child (or the Employee, spouse or child's personal representative).

A rescission is subject to the claims payment and appeal procedures described in Article 12.

4.8 Open Enrollment

The Plan shall conduct Open Enrollment each Calendar Year. During Open Enrollment, Participants may make any of the following changes regarding participation in the Plan, subject to the other governing provisions of this Plan Document.

- Add Dependents not able to enroll during the Calendar Year as Special Enrollees or remove existing Dependents from coverage; and
- Change Plan options or such other changes as permitted by this Plan Document.

4.9 Eligible Retiree's Participation

An Eligible Retiree may participate in the Plan as of the date of retirement from a Member, subject to the following and any other applicable terms and conditions set forth in this Plan Document:

- If a Participant becomes an Eligible Retiree, such Eligible Retiree may continue as a Covered Person until the date the Eligible Retiree becomes eligible for Medicare;
- If an Eligible Retiree's Dependent is not a Covered Person on the day prior to the time the Participant becomes an Eligible Retiree, such Dependents may not thereafter become a Covered Person in the Plan unless the Dependent is a Special Enrollee (see Dependent Enrollment for further information);
- A Dependent spouse acquired by marriage or domestic partnership (where the Member has executed a Rider affording domestic partner coverage) after a Participant becomes an Eligible Retiree may become a Covered Person in the Plan as a Special Enrollee (see Dependent Enrollment for further information);
- If an Eligible Retiree or an Eligible Retiree's Dependent spouse who was a Covered Person terminates participation in the Plan, such person may not thereafter become a Covered Person in the Plan unless the Dependent is a Special Enrollee (see Dependent Enrollment for further information);
- Upon an Eligible Retiree's death or termination of participation due to eligibility for Medicare, any Covered Spouse and Covered Child may remain a Covered Dependent until the earlier of the date of such Covered Spouse's death, termination of participation due to Medicare eligibility, or remarriage. An Eligible Retiree's Dependent who is eligible for Medicare may not be a Covered Person in the Plan;
- Upon an Eligible Retiree's death or termination of participation due to eligibility for Medicare, any Covered Spouse and Covered Child may elect to cancel or reduce their medical coverage at that time.
- Upon the death or retirement of a Participant who is Medicare eligible and who, except for such eligibility for Medicare, would qualify as an Eligible Retiree, any Covered Dependents may remain a Covered Dependent on the same basis as the Covered Dependents of an Early Retiree who is terminating due to death or eligibility for Medicare; and
- If an Eligible Retiree terminates participation in the Plan for any reason other than for death or eligibility for Medicare, the Covered Dependents of such Eligible Retiree shall terminate participation in the Plan as of the Eligible Retiree's termination of participation, at which time no Continuation Coverage shall be provided.

Section 5 Continuation of Coverage

COBRA Continuation Coverage is a temporary extension of group health coverage under the Plan. The right to COBRA Continuation Coverage was created by the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA Continuation Coverage can become available to Qualified Beneficiaries when group health coverage under the Plan ends.

This Section explains COBRA Continuation Coverage, when it may become available and what the Participants need to do to protect the right to receive it.

For additional information about the Participant’s rights and obligations under the Plan and under Federal law, the Participant should contact the Plan Administrator.

5.1 COBRA Continuation Coverage

COBRA Continuation Coverage is available to “Qualified Beneficiaries,” who are Covered Persons whose coverage would otherwise be lost because of a “Qualifying event,” as described below:

- **Participants.** A Participant may elect COBRA Continuation Coverage, (at the Participant’s own expense plus a 2% administration fee) if the Participant’s participation under the Plan terminates as a result of Termination of Employment or reduction of hours with a Member.
- **Gross Misconduct.** The Plan Administrator will not offer COBRA Continuation Coverage for the Participant or any of the Participant’s Dependents where the Plan Administrator determines that the Termination of Employment was due to gross misconduct.
- **Dependents.** A Dependent may elect COBRA Continuation Coverage (at the Dependent’s own expense plus a 2% administration fee) if the Dependent’s participation under the Plan would terminate as a result of one of the following Qualifying events:
 - o Death of a Participant;
 - o A reduction in hours of a Participant;
 - o Termination of Employment of a Participant, except for a termination due to gross misconduct;
 - o Divorce or legal separation from a Participant;
 - o If the Participant cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the divorce or legal separation will be considered a Qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and can establish that coverage was cancelled earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation;
 - o A Dependent child ceases to qualify as a Dependent under the Plan; or
 - o A Participant becomes entitled to Medicare.

Other individuals who may qualify for COBRA Continuation Coverage:

- o **Recipients under Qualified Medical Child Support Orders.** A child of the Participant who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during the Participant’s period of employment with Member is entitled to the same

rights under COBRA as a Dependent child of the Participant, regardless of whether that child would otherwise be considered a Dependent.

- o **Children Born To or Placed for Adoption During COBRA Period.** A child born to, adopted by or placed for adoption with a Participant during a period of Continuation Coverage is considered to be a Qualified Beneficiary provided that, the Participant has elected Continuation Coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Open Enrollment, and lasts for as long as COBRA coverage for other Qualified Beneficiaries of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan requirements.
- o **Participants and Dependents after FMLA.** If a Participant takes leave under FMLA and does not return to work at the end of that leave, the Participant and any Dependents will be entitled to elect COBRA if:
 - They were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); or
 - They will lose Plan Coverage within 18 months because of the Participant's failure to return to work at the end of the leave.

COBRA Continuation Coverage elected in these circumstances will begin on the last day of FMLA leave.

COBRA Continuation Coverage is the same coverage that the Plan gives to other Participants and their Dependents under the Plan that are not receiving COBRA Continuation Coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Participants or Dependents covered under the Plan, including Open Enrollment and Special Enrollment rights.

- o **Duty to Notify Plan Administrator of Qualifying events.** The Plan Administrator must be timely notified in writing that a Qualifying event has occurred in order to be eligible for COBRA Continuation Coverage.
 - Notice must be given by the Employer within **30 days** of the following Qualifying events:
 - Termination of Employment of a Participant;
 - Reduction of hours of a Participant;
 - Death of a Participant;
 - Participant becoming entitled to Medicare; or
 - Bankruptcy of Employer.
 - Notice must be given within **60 days** by the Qualified Beneficiary or its representative, for all other Qualifying events not previously mentioned, following either:
 - The date of the Qualifying event; or
 - The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying event.
 - If the Covered Person provides written notice that does not contain all of the information and documentation required, such notice will nevertheless be considered timely **if all of the following conditions are met:**
 - Notice is mailed or hand delivered by the deadline;

- The Plan Administrator is able to determine the identity of the Employer, Participant and Qualified Beneficiaries, and the Qualifying event from the Notice; and
- The Notice is supplemented with the requested additional information and documentation to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator.

If any of the above conditions are not met, the incomplete Notice will be rejected and COBRA will not be offered.

Caution: If these procedures are not followed or if written notice is not provided to the Plan Administrator within the specified time period, any Participant or Dependent who loses coverage will not be offered the option to elect Continuation Coverage.

Notice Procedures: Any notice must be in writing. Oral notice, or notice by telephone, is not accepted. Participant must mail, e-mail or hand-deliver their notice to the Plan Administrator at this address:

Virginia Private Colleges Benefits Consortium, Inc.
 Attn: Tim Klopfenstein
 118 East Main Street
 P.O. Box 1005
 Bedford, VA 24523
 tim@cicv.org

If mailed, the Participant's notice must be postmarked no later than the last day of the specified time period. Any notice provided must state the name of the Plan (Virginia Private Colleges Benefits Consortium, Inc. Health Plan), the name and address of the Participant covered under the Plan, and the name(s) and address(es) of the Dependent(s) who lost coverage. Participant's notice must also state the Qualifying event and the date it happened.

Forms: The Plan's notice of Qualifying event form should be used to notify the Plan Administrator of a Qualifying event. (A copy of this form can be obtained from the Plan Administrator.) If the Qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Plan's notice of a second Qualifying event (a copy of the form can be obtained from the Plan Administrator) must also state the event and the date it happened. If the Qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Participant's Notice of Disability must also include the name of the disabled qualified Dependent, the date when the Dependent became disabled, the date the Social Security Administration made its determination. Participant's Notice of Disability must include a copy of the Social Security Administration's determination, and a statement as to whether or not the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled (a copy of this form can be obtained from the Plan Administrator).

- **Electing COBRA Continuation Coverage.** The following rules apply to COBRA election:
 - o COBRA Continuation Coverage will begin on the date of the Qualifying event for each Qualified Beneficiary who timely elects COBRA Continuation Coverage;
 - o Each Qualified Beneficiary has an independent right to elect Continuation Coverage;
 - o A Qualified Beneficiary must elect coverage in writing within 60 days of being provided a COBRA Election Notice, using the Plan’s Election Form and following the procedures specified on the Election Form;
 - o Written notice of election must be provided to the Plan Administrator at the address provided on the Plan’s Election Form. If mailed, the election must be postmarked no later than the 60th day of the election time period;
 - o A Participant or Dependent may change a prior rejection of Continuation Coverage at any time during the specified time period by providing the Notice of Election;
 - o A Participant or Dependent who fails to elect Continuation Coverage within the specified time period will lose his or her right to elect Continuation Coverage; and
 - o Unless otherwise indicated, an affirmative election of COBRA Continuation Coverage by a Participant shall be deemed to be an election for that Participant’s Dependents who would otherwise lose coverage under the Plan.

The Participant (i.e. the Employee or former Employee who is or was covered under the Plan), a Qualified Beneficiary with respect to the Qualifying event, or a representative acting on behalf of either may provide the Notice of Election on behalf of all Qualified Beneficiaries who lost coverage due to the Qualifying event described in the Notice.

Note Regarding Failure to Elect: In considering whether to elect Continuation Coverage, Participant should take into account that a failure to continue their group health coverage will affect Participant’s future rights under federal law.

First, the Participant can lose the right to avoid having preexisting condition exclusions applied to Participant by other group health Plans if the Participant has a gap of 63 days or more in health coverage. Election of Continuation Coverage may help Participant avoid such a gap.

Second, the Participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if the Participant does not get Continuation Coverage for the maximum time available to the Participant.

Finally, the Participant should take into account that they have Special Enrollment rights under federal law. The Participant has the right to request Special Enrollment in another group health Plan for which the Participant is otherwise eligible (such as a Plan sponsored by the Participants spouse’s Employer) within 30 days after the Participant’s group health coverage ends. The Participant will also have the same Special Enrollment right’s at the end of Continuation Coverage if the Participant gets Continuation Coverage for the maximum time available to Participant.

- **Length of Continuation Coverage.** COBRA Continuation Coverage is a temporary continuation of coverage. The COBRA Continuation Coverage periods described below are maximum coverage periods.

- **Period of Continuation Coverage for Participants.** A Participant, who qualifies for COBRA Continuation Coverage as a result of Termination of Employment or reduction in hours of employment, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the Qualifying event.

Coverage under this Section may not continue beyond:

- o The date on which the Member ceases to maintain a group health Plan;
 - o The last day of the month for which the required contributions have been made;
 - o The date the Participant becomes entitled to Medicare; or
 - o The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health Plan that is not maintained by the VPC Benefits Consortium, provided the new group Plan does not have a preexisting condition limitation that affects the Participant.
 - o COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Person not receiving COBRA Continuation Coverage (*i.e.* filing fraudulent claims).
- **Period of COBRA Continuation Coverage for Dependents.** If a Dependent elects COBRA Continuation Coverage under the Plan as a result of the Participant's Termination of Employment or reduction in hours of employment as described above, Continuation Coverage may be continued for up to 18 months measured from the date of the Qualifying event. COBRA Continuation Coverage for all other Qualifying events may continue for up to 36 months.

In addition to maximum periods discussed immediately above, Continuation Coverage under this subsection may not continue beyond:

- o The last day of the month for which required contributions have been made;
- o The date the Dependent becomes entitled to Medicare;
- o The date which the Member ceases to maintain a group health Plan; or
- o The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health Plan that is not maintained by the VPC Benefits Consortium provided that the new group Plan does not have a preexisting condition limitation that affects the Dependent.

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Dependent not receiving COBRA Continuation Coverage (*i.e.* such as fraud).

- **Contribution Requirements for COBRA Continuation Coverage.** Participants and Dependents who elect COBRA Continuation Coverage as a result of one of the Qualifying events specified must make Continuation Coverage Payments.

Participants and Dependents must make the Continuation Coverage Payments monthly prior to the first day of the month in which such coverage will take effect. However, a Participant or Dependent has 45-days from the date of an affirmative election to pay the Continuation Coverage Payment for the period between the date medical coverage would otherwise have terminated due to the Qualifying event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Participant and/or Dependent shall have a **31-day** grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the **31-day** grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which

required contributions were made. The **31-day** grace period shall not apply to the **45-day** period for payment of COBRA premiums as set out in this Subsection.

- **Cost of COBRA Continuation Coverage.**

- **Amount.** Each Qualified Beneficiary may be required to pay the entire cost of Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% of the cost to the group health Plan (including both Employer and Participant contributions) for coverage of a similarly situated Plan Participant who is not receiving Continuation Coverage, (or in the case of an extension of Continuation Coverage due to a Disability, 150%).

- **Timely Payment of Premiums.** Participants and Dependents who elect COBRA Continuation Coverage as a result of one of the Qualifying events specified above must make Continuation Coverage Payments.

Participants and Dependents must make the Continuation Coverage Payment monthly prior to the first day of the month in which such coverage will take effect. However, a Covered Person has 45 days from the date of an affirmative election to pay the Continuation Coverage Payment for the period between the date medical coverage would otherwise have terminated due to the Qualifying event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Participant and/or Dependent shall have a **31-day** grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the **31-day** grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which required contributions were made. The **31-day** grace period shall not apply to the **45-day** period for payment of COBRA premiums.

- **Trade Act of 2002.** Two provisions under the Trade Act affect benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive an 80% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional **60-day** period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. Participants should consult the Plan Administrator if he or she believes the Trade Act applies to their situation.

- **Limitation on Participant's Rights to COBRA Continuation Coverage.**

- If a Dependent loses, or will lose medical coverage, under the Plan as a result of a divorce or ceasing to be a Dependent, the Participant or Dependent is responsible for notifying the Plan Administrator within **60 days** of the divorce or loss of Dependent status. Failure to make timely notification will terminate the Dependent's rights to COBRA Continuation Coverage under this Section.

- A Participant or Dependent must complete, sign and return the required enrollment materials within **60 days** from the later of:
 - Loss of coverage; or
 - The date the Plan Administrator or authorized representative of the Plan sends notice of eligibility for COBRA Continuation Coverage.

Failure to enroll for COBRA Continuation Coverage during this 60-day period will terminate all rights to COBRA Continuation Coverage under this Plan. An affirmative election of COBRA Continuation Coverage by a Participant or Participant's spouse shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.

- **Second Qualifying event.** If a second Qualifying event which would entitle a spouse or Dependents to 36 months of Continuation Coverage occurs during an 18-month extension explained above, coverage may be continued for a maximum of 36 months from the date of the first qualifying event provided that the Qualified Beneficiary notifies the Plan Administrator within **60 days** of the second Qualifying event. Such second Qualifying events include the death of a Participant, divorce from a Participant, or a Dependent child ceasing to be eligible for coverage as a Dependent under the Plan. Participant must notify the Plan Administrator within **60 days** after the second Qualifying event using the Notice Procedures previously stated. (Generally, this second Qualifying event extension is not available under the Plan when a Participant becomes entitled to Medicare during the initial 18-month period of Continuation Coverage). **Failure to provide timely notice will result in non-extension of COBRA Continuation Coverage.**
- **Medicare or Other Group Health Coverage.**

Note: Participant must notify the Plan Administrator if any Qualified Beneficiary has become entitled to Medicare and the date of Medicare entitlement.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health Plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA Continuation Coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable preexisting condition exclusions of the other Plan have been exhausted or satisfied).

The rules set forth in Section 10 concerning coordination of benefits with Medicare apply for the period of continuation coverage only when a Qualified Beneficiary was also entitled to Medicare benefits on or before the date on which the Qualified Beneficiary elected COBRA.

- **Extension of COBRA Continuation Period for Disabled Participants.** The period of continuation shall be extended to 29 months (measured from the date of the Qualifying event) in the event:
 - o The Participant is disabled (as determined by the Social Security laws) within **60 days** after the date of the Qualifying event; and
 - o The individual provides evidence to the Plan Administrator or authorized representative of such Social Security Administration determination prior to the earlier of 60 days after the date of the Social Security Administration determination, or the expiration of the initial 18 months of COBRA Continuation Coverage.

In such event, the Plan may charge the individual up to 150% of the amount of the group health Plan cost for the COBRA coverage for all months after the 18th month of COBRA coverage, as long as the disabled Participant is in the covered group. The Participant must notify the Plan Administrator if a Participant is deemed no longer disabled, in which case COBRA Continuation Coverage ends as of the first day of the month that is more than **30 days** after the Social Security Administration determination.

Notice Regarding Individual Policies: The Health Insurance Portability and Accountability Act (“HIPAA”) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a preexisting condition exclusion. To take advantage of this HIPAA right, Participant must elect Continuation Coverage under the Plan, and retain the coverage (by paying the required contribution) for the duration of Participant’s 18, 29, or 36 month Continuation Coverage. Participant must then apply for coverage with an individual insurance carrier before Participant has a Significant Break in Coverage.

For general information regarding the Plan’s COBRA coverage, Participant can contact Tim Klopfenstein at (540) 586-1803 or by mail at Virginia Private Colleges Benefits Consortium, Inc., 118 East Main Street, P.O. Box 1005, Bedford, VA 24523.

5.2 Michelle’s Law

A covered Dependent will not lose his status as a covered Dependent while on a Medically Necessary Leave of Absence. A “Medically Necessary Leave of Absence” is a leave of absence from a post-secondary educational institution that:

- Commences while the Dependent is suffering from a severe Illness or Injury;
- Is Medically Necessary (as certified by the Dependent’s Doctor); and
- Causes the Dependent to lose full time student status under the Plan.

Coverage may not terminate due to the Medically Necessary Leave of Absence until the earlier of:

- One year after the first day of the Medical Necessary Leave of Absence; or
- The date the coverage would otherwise terminate under the Plan.

(Section 5.2 may not be applicable due to the ACA’s age 26 Dependent care mandate.)

5.3 USERRA Coverage

Participants Have Rights Under Both COBRA and USERRA. Participant’s rights under COBRA and USERRA are similar but not identical. Any election that Participant makes pursuant to COBRA will also be an election under USERRA. COBRA and USERRA will both apply with respect to the Continuation Coverage elected. If COBRA or USERRA gives Covered Persons different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) established requirements that Employers must meet for certain Employees who are involved in the Uniformed Services. In addition to the rights that Participant has under COBRA, Participant is entitled under USERRA to continue the coverage Covered Persons had under the VPC Benefits Consortium.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty pursuant to orders issued under federal law, and the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of War or national Emergency.

Service in the Uniformed Services or Service means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, the time necessary for a person to be absent

from employment for an examination to determine the fitness of the person to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain duty and training by intermittent disaster response personnel of the National Disaster Medical System.

- **Duration of USERRA Coverage.**

- **General rule 24 months maximum.** When a Participant takes a leave for service in the Uniformed Services, USERRA coverage for the Participant (and Covered Dependents for whom coverage is elected) begin the day after the Participant (and Covered Dependents) lose coverage under the Plan, and it may continue for up to 24 months. However, USERRA coverage will end earlier if one of the following events takes place:
 - Participant fails to make a premium payment within the required time;
 - Participant fails to return to work within the time frame required under USERRA (see below) following the completion of Participant’s service in the Uniformed Services; or
 - Participant loses rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.
- **Returning to Work.** Participant’s right to continue coverage under USERRA will end if Participant does not notify the Employer of the intent to return to work within the time frame required under USERRA following the completion of Participant’s service in the Uniformed Services by either reporting to work (when absence was for less than 31 days) or applying for reemployment (if absence was for more than 30 days). The time for returning to work depends on the length of the absence, as follows:

Period of Absence	Return to Work Requirement
Less than 31 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 30 days but less than 181 days	Submit an application for employment not later than 14 days after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 180 days	Submit an application for employment not later than 90 days after the completion of the service.
Any period, if the absence was for purposes of an examination for fitness to perform service	Report to work at the beginning of the first regularly-scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
Any period if Participant was Hospitalized for or are convalescing from an Injury or Illness incurred or aggravated as a result of Participant’s service	Apply for work or submit application as described above (depending on length of absence) when recovery is over, but recovery time is limited to two years. The 2 year period is extended by any minimum time required to accommodate circumstances beyond the Employee’s control that make compliance with these deadlines unreasonable or impossible.

- o **Concurrent.** COBRA coverage and USERRA coverage begin at the same time and run concurrently. However, COBRA coverage can continue longer, depending on the Qualifying event, and is subject to different early termination provisions. In contrast, USERRA coverage can continue for up to 24 months, as described earlier in this Section.
- o **Premium Payments for USERRA Continuation Coverage.** If Participant elects to continue health coverage pursuant to USERRA, the Participant will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if Participant's Uniformed Services leave of absence is less than 31 days, Participant is not required to pay more than the amount that Participant would pay as an active Employee for that coverage.

5.4 Family and Medical Leave Act

If a Participant is on a Family or Medical Leave of Absence, the Participant may continue coverage in accordance with the Family and Medical Leave Act of 1993 ("FMLA"), and the Plan will continue coverage, as if the Participant was Actively at Work as long as the following conditions are met:

- The required Contribution is paid; and
- The Participant has written approval of leave from the Member.

Coverage will be continued for up to the greater of:

- The leave period required by FMLA and any amendments thereto or regulations promulgated thereunder; or
- The leave period required by applicable state law.

If coverage is not continued during a Family or Medical Leave of Absence, when the former Participant returns to Actively at Work status and re-enrolls in the Plan, no new Waiting Period will apply.

Section 6 Prescription Drugs

6.1 Preventive Care Medications

The Affordable Care Act requires the Plan to provide coverage for certain recommended preventive services and Preventive Care medications without the application of any Copayment, Deductible or Coinsurance. These Preventive Care services and medications will be covered by the Plan at 100%. All Preventive Care medications require a prescription from a licensed health care provider and must be obtained through the Plan's Prescription Drug card program to be covered at 100%.

The Plan may provide 100% coverage for certain additional medications. Coverage of these additional medications may vary by plan. Medications may be added or removed from the lists of covered medications at the sole discretion of the Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc. without prior notice to Covered Person.

Covered Persons may call Member Services at the number on the back of their ID card for additional information about these preventive services and medications. Covered Persons may also visit the federal government website for a complete list of Affordable Care Act required preventive services and medications.

The website is found at: <https://www.healthcare.gov/preventive-care-benefits/>

6.2 Preventive Rx Drugs

Preventive Rx drugs are selected drugs used in the management of Asthma, Diabetes, Hypertension, and Hyperlipidemia. These drugs are covered at no charge to Covered Persons.

Medications are under continual review, and may be added to or removed from the list of Preventive Rx drugs at the sole discretion of the Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc. at any time without prior notice to Covered Persons. Therefore, please access the current list of Preventive Rx drugs by calling, toll-free, 833-389-1968.

6.3 Retail Prescription Program

To receive drug benefits under the Plan, a Covered Person can purchase Prescription Drugs from a pharmacy in amounts up to a 90-day supply as further described in the associated SBCs.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacy to call its pharmacy benefits manager ("PBM") and ask for an override for one early refill. If you need more than one early refill, please call Member Services at the number on the back of your ID card.

6.4 Mail Service Prescription Program

A Covered Person can order long-term Maintenance Prescription Drugs by mail order in amounts up to a 90-day supply as further described in the associated SBCs.

Notice: This Plan uses one or more drug formulary (i.e. a list of drugs for which coverage is provided or Doctors are encouraged or offered incentives to provide.) The presence of a drug on the Plan's list does not guarantee a Doctor will prescribe it.

6.5 Limitations and Exclusions

This section refers only to Prescription Drugs. A complete list of all medical services excluded under this Plan is provided in Section 8.

The following Prescription Drugs are limited or excluded from the Prescription Drug card Program:

- Drugs used for artificial methods of conception;
- Cosmetic indications and anti-wrinkle agents (e.g. Renova) for individuals 35 years or older;
- Dermatologicals and hair growth stimulants (e.g. Rogaine);
- Drugs covered under Workers Compensation, Medicare or Medicaid;
- Growth hormones, unless Preauthorized;
- Fertility/infertility medications;
- Injectibles (Insulin and other injectibles specifically approved by the Plan are Covered Services and not subject to this exclusion);
- Non-legend drugs other than those specifically listed (a non-legend drug is one for which no prescription is required by state or federal law);
- Prescription Drugs or medications used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmia, and decreased libido (e.g. Viagra), except where such sexual dysfunction is caused by surgery (e.g. prostate surgery), are limited to 6 tablets per month;
- Smoking deterrent medications are covered for over the counter and prescriptions drugs for smoking cessation;
- Vitamins or minerals, singly or in combination. Exception: Legend prenatal vitamins are covered for pregnancy;
- Therapeutic devices or appliances, including support garments, respiratory chambers (e.g. Aerochamber), ostomy supplies, and other non-medicinal substances;
- Charges for administration or injection of any drug;
- Drugs labeled, "Caution-limited by federal law to investigational use," or Experimental Procedures, even though a charge is made to the individual;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, Ambulatory Care Facility, Extended Care Facility, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Other Facility Provider, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals; and
- Over-the-counter drugs.

Coverage may not be excluded for any Prescription Drug approved by the Food and Drug Administration that has been proven effective and is acceptable to treat the specific type of cancer for which the Prescription Drug has been prescribed by either: (1) the American Medical Association Drug Evaluations; (2) the American Hospital Formulary Service Drug Information; or (3) the United States Pharmacopoeia Drug Information.

Any drug listed by brand name in this Section shall include its generic equivalent when available.

6.6 Financial Credits

Financial credits from drug manufacturers based on the total volume of claims processed for their products utilized by Participants are used to reduce Plan costs and fees for administering the program. Reimbursements to pharmacies are not affected by these credits.

6.7 Tier 4 Drugs

Participants who use certain covered Tier 4 (formerly “specialty”) drugs must purchase them through the specialty pharmacy network of their pharmacy claims processor. Information about the Plan’s specialty pharmacy may be obtained by contacting the pharmacy claims processor, IngenioRx, at (833) 389-1968.

Tier 4 drugs will be covered only when obtained through the specialty pharmacy network. Tier 4 drugs are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance.

6.8 Automated Accumulator Prescription Drug Program

For certain Prescription Drugs, manufacturer copays, coupons or other manufacturer cost sharing assistance payments, whether made directly or indirectly, do not apply to the satisfaction of your Deductible or to your Out-of-Pocket Maximum. Contact IngenioRx at (833) 389-1968 if you have questions or need more information about this program.

6.9 Variable Copay Prescription Drug Program

Copays for certain Prescription Drugs may be set higher than the standard Copayment in order to benefit from Copayment assistance provided by manufacturer programs designed to help you reduce your pharmacy costs. Your actual Copayment will be adjusted to be no higher than your standard Copayment so that your actual Out-of-Pocket cost will remain the same or lower.

Section 7 Covered Services

All benefits are subject to the terms, conditions, definitions, limitations, and exclusions described in this Plan Document. Only Medically Necessary Covered Services will be provided by the HMO. If a service is not considered Medically Necessary, you will be responsible for the charges. Additionally, we will only pay the charges incurred by you when you are actually eligible for the Covered Services received (for example, the premium has been paid by you or on your behalf).

The following pages describe the benefits available to you under this Plan Document.

7.1 Comprehensive Major Medical Expense Benefit

The Comprehensive Major Medical Expense Benefit provides coverage for a wide range of services called Covered Services. The services associated with this benefit are covered to the extent that they are:

- Medically Necessary;
- Prescribed by or given by a Doctor;
- Allowable Charges; and
- Provided for care and treatment of a covered Illness or Injury.

Benefits are payable in accordance with the applicable Deductible amounts and benefit percentages listed in the associated SBCs, unless otherwise listed as a Covered Expense.

7.2 Ambulance Services.

Medically Necessary ambulance services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Doctor's office or clinic;
- A morgue or funeral home.

Important Notes on Air Ambulance Benefits: Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Air Ambulance Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you.

Note: Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

7.3 Autism Services

Your coverage includes certain treatments associated with autism spectrum disorder (ASD). Coverage for ASD includes but is not limited to the following:

- Behavioral health treatment;
- Diagnosis of autism spectrum disorder;
- Treatment of autism spectrum disorder;
- Pharmacy care
- Psychiatric care

- Psychological care; and
- Therapeutic care

Treatment for ASD includes Applied Behavioral Analysis when provided or supervised by a board certified behavior analyst, licensed by the Board of Medicine, and billed by such behavior analyst, and the prescribing practitioner is independent of the provider of the Applied Behavioral Analysis.

7.4 Clinical Trial Costs

Your coverage includes benefits for clinical trial costs. Clinical trial costs means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer or other life-threatening disease or condition. The criteria for these costs is found in Exhibit A.

7.5 Dental Services

No dental services are provided except for the following:

- Medically Necessary dental services resulting from an accidental dental Injury, regardless of the date of such Injury. For an Injury that occurs on or after your Effective Date of coverage, you must seek treatment within 60 days after the Injury. You must submit a plan of treatment from your Dentist or oral surgeon for approval by the HMO for a dental Injury. No approval of a plan of treatment by the HMO is required for Emergency treatment of a dental Injury;
- The cost of dental services and dental appliances only when required to diagnose or treat an accidental Injury to the teeth;
- The repair of dental appliances damaged as a result of an accidental Injury to the jaw, mouth or face;
- Dental services to prepare the mouth for radiation therapy to treat head and neck cancer; or
- Covered general anesthesia and Hospitalization services for children under the age of 5, Covered Persons who are severely disabled, and Covered Persons who have a medical condition that requires admission to a Hospital or Outpatient Surgery facility. These services are only provided when it is determined by a licensed Dentist, in consultation with the Covered Person's treating Physician that such services are required to effectively and safely provide dental care.

Helpful tip: The HMO provides coverage only for functional repairs. Services of a cosmetic nature, or not deemed to be functional by the HMO, are not Covered Services.

7.6 Diabetic Supplies, Equipment, and Education

Your coverage provides for medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:

- Insulin pumps;
- Home blood glucose monitors, lancets, blood glucose test strips, syringes and hypodermic needles and syringes when received from an HMO pharmacy; and
- Outpatient self-management training and education performed in-person, including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

7.7 Diagnostic Tests

Your benefits include coverage for the following procedures when performed by the designated HMO Providers to diagnose a definite condition or disease because of specific signs and/or symptoms:

- Radiology (including mammograms), ultrasound or nuclear medicine;
- Laboratory and pathology services or tests;
- Diagnostic EKGs, EEGs; and
- Advanced diagnostic imaging services (includes magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), magnetic resonance spectroscopy (MRS), positron emission tomography (PET) scan, computed tomography (CT) scan, and computed tomographic angiography (CTA).

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a Hospital stay is covered under your benefits only when:

- Your medical condition requires that medical skills be constantly available;
- Your medical condition requires that medical supervision by your Doctor is constantly available; or diagnostic services and equipment are available only as an Inpatient.

Helpful tip: Medical supplies and other services that may be required and provided in conjunction with a diagnostic test are not considered part of the diagnostic test. Therefore, if a facility or provider bills a separate charge for such services or supplies, benefits for such services or supplies will be provided as described in the associated SBCs for such services and supplies and not as part of the diagnostic test.

7.8 Dialysis

Your coverage provides for dialysis treatment, including hemodialysis and peritoneal dialysis. These are treatments of severe kidney failure or chronic poor functioning of the kidneys.

7.9 Doctor Visits and Services

Your coverage provides for:

- Visits to a Doctor's office or your Doctor's visits to your home;
- Visits to an urgent care center;
- Visits to an Ambulatory Surgical Facility;
- Doctor visits in a Hospital Outpatient department or Emergency room;
- Visits for shots needed for treatment (for example, allergy shots);
- Interactive Telemedicine Services; and
- Nutritional Counseling. Coverage for eating disorders. Coverage will be limited to medical providers and will not include coverage for traditional weight loss plans such as Weight Watchers, Jenny Craig, etc. Coverage will also not include access to personal trainers, gym facilities, etc.

7.10 Early Intervention Services

Your coverage includes benefits for early intervention services for covered Dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services (“the Department”) as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of:

- Speech and language therapy;
- Occupational therapy;
- Physical therapy; and
- Assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be Medically Necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without affecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not Medically Necessary.

7.11 Emergency Room Care

Your benefits include coverage for Emergency room visits, services, and supplies necessary for the treatment of an Emergency as defined in the Glossary section of this Plan Document.

The HMO will participate in coordinating your care if you are admitted to the Hospital from the Emergency Room. You or a representative on your behalf should notify the HMO within 48 hours after you begin receiving care. This applies to services received within or outside the Service Area.

7.12 Home Health Care Services

When authorized by the HMO, we cover treatment provided in your home on a part-time or intermittent basis. This coverage allows for an alternative to repeated Hospitalizations that will provide the quality and appropriate level of care to treat your condition. To ensure benefits, your Doctor must provide a description of the treatment you will receive at home. Your coverage includes the following home health services:

- Visits by a licensed health care professional, including a nurse, therapist, or home health aide; and
- Physical, speech, and occupational therapy (services provided as part of home health are not subject to separate visit limits for therapy services).

These services are only covered when your condition confines you to your home at all times except for brief absences.

7.13 Hospice Care Services

Hospice Care will be covered, for Covered Persons diagnosed with a Terminal Illness with a life expectancy of six months or less. Covered Services include the following:

- Skilled Nursing Care, including IV therapy services;
- Drugs and other Outpatient prescription medications for palliative care and pain management;
- Services of a medical social worker;
- Services of a home health aide or homemaker;

- Short-term Inpatient Care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute Inpatient Care for the Covered Person in order to provide the Covered Person's primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided for more than five days every 90 days;
- Physical, speech, or occupational therapy (services provided as part of Hospice Care are not subject to separate visit limits for therapy services);
- Durable Medical equipment;
- Routine medical supplies;
- Routine lab services;
- Counseling, including nutritional counseling with respect to the Covered Person's care and death; and
- Bereavement counseling for immediate Family members both before and after the Covered Person's death.

7.14 Hospital Services

Your coverage provides benefits for the Hospital and Doctors' services when you are treated on an Outpatient basis, or when you are an Inpatient because of Illness, Injury, or pregnancy. (See the Maternity Covered Service in this section for an additional discussion of pregnancy benefits.) Your benefits include coverage for Medically Necessary care in a semi-private room or intensive or special care unit. This includes your bed, meals, special diets, and general nursing services.

In addition to your semi-private room, general nursing services and meals, your coverage includes Maximum Allowed Amounts for Medically Necessary services and supplies furnished by the Hospital when prescribed by HMO Physicians.

While you are an Inpatient in the Hospital, you have coverage for the Medically Necessary services rendered by HMO Physicians and other HMO Providers.

Helpful tip: All non-Emergency Inpatient Hospital stays must be approved in advance, except Hospital stays for vaginal or cesarean deliveries without complications.

7.15 Private Room

Your Inpatient Hospital benefits include a stay in a semi-private room unless a private room is approved in advance by the HMO. We will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your Inpatient benefits will cover the Hospital's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your Copayment and Coinsurance (if any).

7.16 Individual Case Management

In addition to the Covered Services specified in this Plan Document, the HMO may elect to offer benefits for an alternative treatment plan plus services on a case by case basis. The HMO shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that the alternative services are Medically Necessary and cost-effective. Nothing shall prevent a Covered Person from appealing the HMO's decision that an

alternative service is Medically Necessary. The total benefits paid for such services will not exceed the maximum benefits to which the Covered Person would otherwise be entitled under this Plan Document in the absence of alternative benefits. If the HMO elects to provide alternative benefits for a Covered Person in one instance, it shall not obligate the HMO to provide the same or similar benefits for any Covered Person in any other instance, nor shall it be construed as a waiver of the HMO's right to administer this Plan Document in strict accordance with its express terms.

Also, from time to time the HMO may offer a Covered Person and/or their HMO Provider information and resources related to disease management and wellness initiatives. These services may be in conjunction with the Covered Person's medical condition or with therapies that the Covered Person receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

7.17 Infusion Services

When authorized by the HMO, we cover infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medical and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

Helpful tip: Infusion services may be received at multiple sites of service, including facilities, Professional Provider offices, ambulatory infusion centers and from home infusion providers. Benefits may vary by place of service, and where you choose to receive Covered Services may result in a difference in your Copayment and/or Coinsurance. Please see the Infusion services section on the associated SBCs for a description of the benefits by place of service.

7.18 Lymphedema

Your coverage includes benefits for expenses incurred in connection with the treatment of lymphedema.

7.19 Maternity

Prenatal and newborn care

If the Participant or Participant's Dependent becomes pregnant, your HMO provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the Hospital are covered.

For an uncomplicated vaginal delivery, this Plan will cover a 48 hour Hospital stay. For an uncomplicated cesarean delivery, the Plan will cover a 96-hour Hospital stay. If a decision is made to discharge a mother or newborn before the expiration of the minimum hours, listed above, coverage is provided for timely post-delivery care by a Doctor, Midwife, Registered Nurse, or other appropriate licensed health care provider and may be provided at the mother's home, a health care provider's office, or a Health Care Facility.

Your benefits include:

- Home setting covered with nurse midwives;
- Anesthesia services to provide partial or complete loss of sensation before delivery;
- Hospital services for routine nursery care for the newborn during the mother's normal Hospital stay;
- Prenatal and postnatal care services for pregnancy and Complications of Pregnancy for which Hospitalization is necessary;
- Home Health Care Services for postnatal care;

- Circumcision of a covered male Dependent;
- Services for interruption of pregnancy;
- Use of the delivery room and care for normal deliveries; and
- Fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

Future Moms

A Participant or Participant's covered Dependent is eligible to participate in Future Moms. This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A Future Moms consultant is assigned to women as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her Doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery. As soon as pregnancy is confirmed, sign up for the program by calling 800-828-5891. You will receive:

- A kit containing educational material on how to get proper prenatal care and identify signs of premature labor;
- A risk appraisal to identify signs of premature labor; and
- After delivery, a birth kit and child care book.

Helpful tip: See the Enrollment and Contributions section for details on when and how to enroll a newborn.

7.20 Medical Equipment (durable)

We cover the rental (or purchase if that would be less expensive) of Medical equipment (durable) when obtained from an HMO Medical equipment (durable) provider. Also covered are maintenance and necessary repairs of Medical equipment (durable) except when damage is due to neglect.

Examples of covered Medical equipment (durable) include:

- Nebulizers;
- Hospital type beds;
- Wheelchairs;
- Traction equipment;
- Walker; and
- Crutches.

7.21 Medical Devices and Appliances

We cover the cost of fitting, adjustment, and repair of the following items when prescribed for Activities of Daily Living:

Examples of covered medical devices include:

- Orthopedic braces;
- Leg braces, including attached or built-up shoes attached to the leg brace;

- Molded, therapeutic shoes for diabetics with peripheral vascular disease;
- Arm braces, back braces, and neck braces;
- Head halters;
- Catheters and related supplies;
- Orthotics, other than foot orthotics; and
- Splint.

7.22 Medical Formulas

We cover special medical formulas which are the primary source of nutrition for Covered Persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a Physician and required to maintain adequate nutritional status.

7.23 Medical Supplies and Medications

Your coverage includes benefits for medical supplies and medications. Examples of medical supplies include:

- Hypodermic needles and syringes;
- Allergy serum;
- Oxygen and equipment (respirators) for its administrators; and
- Non-injectable prescription medications provided by your Doctor.

7.24 Injectable Medications

Your coverage includes benefits for self-administered injectable medications obtained through a retail pharmacy or administered by an HMO Provider.

7.25 Prosthetic Devices and Components

Your coverage includes benefits for prosthetic devices. A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot, or eye. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

7.26 Mental Health or Substance Use Disorder Treatment

Accessing your mental health services and Substance Use Disorder services (treatment of alcohol or drug dependency) is easy. In fact, you have a dedicated department available to you simply by calling 800-991-6045. These services require Preauthorization from the HMO. You can select any mental health and Substance Use Disorder provider listed in your HMO Provider directory. Or if you are unsure of which provider to see, call 800-991-6045 and the representative will be able to match you with a provider who seems best suited to meet your needs.

Inpatient treatment

You have coverage for Inpatient Care for mental health services and Substance Use Disorder services. Your coverage includes individual psychotherapy, group psychotherapy, psychological testing, counseling with Family members to assist with the patient's diagnosis and treatment, and convulsive therapy treatment. Please note

that Inpatient services for Substance Use Disorder must be provided in a Hospital or Substance Use Disorder Treatment Facility which is licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care. Coverage includes residential treatment.

Partial day services

You also have coverage for partial day mental health services and Substance Use Disorder services. A partial day program must be licensed or approved by the state and must include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or Substance Use Disorder, or an intensive Outpatient program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence.

Outpatient treatment

Your coverage includes treatment for Outpatient Mental health and Substance Use Disorder services.

Medication management

visits to your HMO Physician to make sure that medication you are taking for a mental health or Substance Use Disorder problem is working and the dosage is right for you are covered.

7.27 Morbid Obesity

You have coverage of certain treatments for Morbid Obesity including selected surgical procedures recognized by the National Institutes of Health (NIH). To qualify, Covered Persons must be age 18 or older and have a body mass index (BMI) of 40.0 or greater, where BMI equals weight in kilograms divided by height in meters squared. Coverage does not include weight control dietary supplements or weight loss medications, unless such supplements are recognized by the NIH as effective treatment for the long-term reversal of Morbid Obesity for Covered Persons meeting the requirements specified above. Precertification is required. A separate copay which does not apply to or count toward the Out-of-Pocket Maximum applies. The procedure must be performed at an identified Bariatric Surgery center of excellence in the Network.

Note: Coverage is not available for the treatment of Morbid Obesity under Plan 8.

Out-of-Plan Benefits are not available for Obesity and coverage is not available Out-of-Network. More complete information, including the VPC Benefits Consortium Bariatric Surgery Policy, is available from the Plan Administrator.

7.28 Obstetrician-Gynecologist Physician Services

All female Covered Persons may receive services from an obstetrician-gynecologist who is an HMO Physician without a referral for the care of or related to the female reproductive system and breasts. The obstetrician-gynecologist must obtain authorization from the HMO for Inpatient Hospital services and Outpatient Surgery.

7.29 Skilled Nursing Facility Stays

The following items and services will be provided to you as an Inpatient in a skilled nursing bed of an HMO Provider Skilled Nursing Facility or in a skilled nursing bed in an HMO Provider Hospital:

- Room and board in semi-private accommodations;
- Rehabilitative services; and
- Drugs, biological, and supplies furnished for use in the Skilled Nursing Facility and other Medically Necessary services and supplies.

Your Inpatient Skilled Nursing Facility benefits include a stay in a semi-private room unless a private room is approved in advance by the HMO. We will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your Inpatient benefits would cover the Skilled Nursing Facility's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your Copayment and Coinsurance (if any).

Custodial or residential care in a Skilled Nursing Facility or any Other Facility is not covered except as rendered as part of Hospice Care.

7.30 Spinal Manipulation and Manual Therapy Services

Your coverage includes Spinal Manipulation and manual medical therapy services when performed by a provider within the American Specialty Health Networks (ASHN). Covered Services include examination, re-examination, manipulation, conjunctive therapy, radiology, Durable Medical Equipment, and laboratory tests related to the delivery of these services.

To receive care, please visit our website at www.anthem.com, or contact ASHN directly for a list of ASHN providers. Then, simply contact a participating ASHN provider to make an appointment. The ASHN provider is responsible for obtaining authorization prior to providing care.

Out-of-Plan

If you wish to receive care from a non-ASHN provider, contact ASHN directly for authorization. If authorization is not received, you will be responsible for all costs related to these services.

Questions concerning ASHN providers may be directed to ASHN's network department at 800-972-4426. Questions concerning coverage may be directed to ASHN's customer service department at 800-678-9133. Both departments are open 9:00 a.m. to midnight, Eastern Standard Time, Monday-Friday, and noon to 8:00 p.m. Eastern Standard Time, Saturday-Sunday.

7.31 Surgery

General surgery

Your coverage includes benefits for surgery services when approved in advance by the HMO and when treatment is received at an Inpatient, Outpatient, or Ambulatory Surgical Facility, or Doctor's office. We will not pay separately for pre- and post-operative services.

Oral surgery

Your benefits include oral surgery for:

- Surgical services on the hard or soft tissue in the mouth when the main purposes is not to treat or help the teeth or their supporting structures;
- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
- Orthognathic surgery that is required because of a medical condition or Injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part.

Organ and tissue transplants, transfusions

We cover organ and tissue transplants and transfusions. When a covered human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive the benefits of this Plan Document.

Helpful tip: Certain organ or tissue transplants are considered Experimental/Investigative or not Medically Necessary. Coverage for organ and tissue transplants is determined through the Preauthorization process.

Autologous bone marrow transplants for breast cancer are covered, only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in High dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the Plan of Experimental/Investigative services.

Reconstructive breast surgery

Mastectomy, or the surgical removal of all or part of the breast, is a Covered Service. Also covered are:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Covered Person.

7.32 Therapy

Cardiac rehabilitation therapy

Your coverage includes benefits for cardiac rehabilitation which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

Chemotherapy

Your coverage includes benefits for the treatment of disease by chemical or biological antineoplastic agents.

Physical, occupational and speech therapy

Your coverage includes benefits for short-term physical, occupational, and speech therapy when the treatment is Medically Necessary for your condition. In the judgment of the HMO, short-term rehabilitative therapy services can be expected to result in significant improvement of your condition within 90 consecutive days of beginning Outpatient treatment. Refer to the associated SBCs for limitations, Copayment and Coinsurance amounts.

Physical therapy is treatment by physical means to relieve pain, restore function, and prevent Disability following disease, Injury, or loss of limb. Your coverage includes benefits for physical therapy to treat lymphedema.

Occupational therapy is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed and bathing.

Speech therapy is treatment for the correction of a speech impairment which results from disease, surgery, Injury, congenital anatomical anomaly or prior medical treatment.

Helpful tip: Long term therapy or rehabilitative care is excluded unless otherwise specified in this Plan Document as covered under Early Intervention Services.

Radiation therapy

Your benefits include radiation therapy including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

Respiratory therapy

Your benefits include respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat Illness or Injury.

7.33 Vision Correction After Surgery or Accident

In situations such as those defined below, your coverage includes the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental Injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- Prescribed to replace the human lens lost due to surgery or Injury;
- “Pinhole” glasses are prescribed for use after surgery for a detached retina; or
- Lenses are prescribed instead of surgery in the following situations:
 - Contact lenses are used for the treatment of infantile glaucoma;
 - Corneal or sclera lenses are prescribed in connection with keratoconus;
 - Sclera lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
 - Corneal or sclera lenses are required to reduce a corneal irregularity other than astigmatism.

7.34 Preventive Care Services

Your coverage provides for Preventive Care services for children, adolescents and adults. Preventive Care services generally include check-up visits, developmental assessment and guidance, screening tests, intervention counseling/education services, immunizations and other services to prevent the development of disease, or allow the detection of medical conditions in advance.

Services are covered as Preventive Care for children, adolescents and adults with no current symptoms or prior history of the medical condition associated with the screening or service. Covered Persons 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 benefits.

Additionally, a routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary Covered Services, these services will generally be covered as diagnostic and/or surgical services and not as Preventive Care services. Also covered screenings that you undergo because you have a personal or Family history of a particular condition are not generally covered as Preventive Care services. Deductibles, Copayments, and Coinsurance amounts applicable to diagnostic and/or surgical services may be different from those applicable to Preventive Care services. Please see the associated SBCs for more information.

The Preventive Care services in this section meet the requirements outlined under federal and state law. Many Preventive Care services covered by your health Plan are not subject to cost shares (for example, Deductible,

Copayment, and/or Coinsurance amounts). That means the HMO pays 100% of the Maximum Allowed Amount. **Cost shares will apply when services are received from non-HMO Providers.**

These Preventive Care services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
 - Breast cancer;
 - Cervical cancer;
 - Colorectal cancer;
 - High blood pressure;
 - Type 2 diabetes mellitus;
 - Cholesterol;
 - Child and adult obesity, including counseling services related to nutrition;
 - Certain over-the-counter (OTC) items and services when prescribed by a health care provider, including aspirin, folic acid supplement, vitamin D supplement, iron supplement, and bowel preparations. Age and gender and quantity limitations apply; and
 - Tobacco-cessation counseling, Prescription Drugs, and nicotine replacement therapy products when prescribed by a provider, including over-the-counter (OTC) nicotine gum, lozenges and patches for Covered Persons age 18 and older. Tobacco cessation Prescription Drugs and OTC items are limited to a no more than a 180-day supply per 365 days.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive Care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. The health plan covers additional Preventive Care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - Women’s contraceptives including all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and counseling. Contraceptive coverage includes generic and single-source brand drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Standard multi-source brand drugs will be covered as a Preventive Care benefit when Medically Necessary, otherwise, they will be covered under the Prescription Drug benefit.
 - Breastfeeding support, supplies, and counseling. Standard benefits for breast pumps are limited to one pump per pregnancy.
 - Gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
 - Testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of pap smear results.
 - Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.

- Screening and counseling for interpersonal and domestic violence.
- Well woman visits.
- Breast Cancer Susceptibility Gene (BRCA) screening, counseling, and genetic testing for women at higher risk.

Covered Persons may obtain additional information about these Preventive Care services by contacting Member Services. Covered Persons may also visit the federal government websites:

- <https://www.healthcare.gov/coverage/preventive-care-benefits/>;
- <https://www.ahrq.gov/>; or
- <http://www.cdc.gov/vaccines/acip/index.html>

The Plan also covers the following as required by state law:

- Routine screening mammograms.
- Annual Pap smear for testing performed by any FDA-approved gynecologic cytology screening technologies.
- Annual prostate cancer screenings and digital rectal exam, including PSA test for males who are at least 50 years old or at least 40 years old who are at high risk for prostate cancer.

Routine vision care

Your coverage includes benefits for one eye exam each Calendar Year. In order to receive in-plan benefits, you will need to receive vision care from a Blue View Vision Participating Provider. If you elect to receive care from a provider who does not participate in the Blue View Vision network, you will receive Out-of-Plan Benefits. For additional information about benefits or a participating location, please consult your provider directory or contact Member Services.

When you must file a vision claim

Network providers file claims on your behalf. You may have to file a claim if you receive care from a provider that does not participate in the Blue View Vision network. To file a claim follow these 3 steps:

1. Call 833-597-2358 to order a claim form. You can also download a vision claim form at your www.anthem.com member self-service portal.
2. Complete and sign the claim form. Attach all itemized bills for Covered Services. Each itemized bill must contain the following.
 - o Name and address of the person or organization providing services or supplies;
 - o Name of the patient receiving services or supplies;
 - o Date services or supplies were provided;
 - o The charge for each type of service or supply; and
 - o A description of the services or supplies received.
3. Send the completed claim form and itemized bill(s) to:

Blue View Vision, OON Claims
 P. O. Box 8504
 Mason, OH 45040-7111

7.35 Wigs or Scalp Hair Prosthesis

Purchase of a scalp hair prosthesis when necessitated by hair loss due to the medical condition known as alopecia areata, or as the result of hair loss due to radiation or chemotherapy for diagnosed cancer. Limited to one (1) per Participant per Calendar Year. Subject to approval by Case Management.

Section 8
Limitations and Exclusions on Covered Services (Exclusions)

This list of services and supplies are excluded from coverage under this Plan Document. They will not be covered in any case.

A

Your coverage does not include benefits for **acupuncture**.

Your coverage does not include benefits for services received which are not **Preauthorized by the HMO**, unless otherwise specified in this Plan Document.

B

Your coverage does not include benefits for **biofeedback therapy**.

C

Your coverage does not include benefits for over-the-counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, diapers, and ice bags.

Your coverage does not include benefits for, or related to, **Cosmetic Surgery or procedures**, including complications that directly result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a Cosmetic Surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. The HMO will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

Your coverage does not include benefits for the following **dental** or oral surgery services:

- Shortening or lengthening of the mandible or maxillae for cosmetic purposes;
- Surgical correction of malocclusion or mandibular retrognathia unless such condition creates significant functional impairment that cannot be corrected with orthodontic services;
- Dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia;
- Medications to treat periodontal disease;
- Treatment of natural teeth due to diseases;
- Treatment of natural teeth due to accidental Injury occurring on or after your Effective Date of coverage, unless treatment was sought within 60 days after the accidental Injury and you submitted a treatment plan to the HMO for prior approval. No approval of a plan of treatment by the HMO is required for Emergency treatment of a dental Injury;
- Biting and chewing related injuries;
- Restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth;
- Extraction of either erupted or impacted wisdom teeth; and

- Anesthesia and Hospitalization for dental procedures and services except as specified on page 16 of this Plan Document.

Your coverage does not include benefits for **donor** searches for organ or tissue transplants, including compatibility testing of potential donors who are not immediate blood-related Family members (parent, child, sibling).

E

Your coverage does not include benefits for services or supplies primarily for **educational**, vocational, or self management/training purposes, except as otherwise specified in this Plan Document.

Your coverage does not include benefits for **Experimental/Investigative** procedures as well as services related to or complications that directly result from such procedures except for clinical trials for cancer or other life-threatening disease or condition. The criteria for deciding whether a service is Experimental/Investigative or a clinical trial cost for cancer or other life-threatening disease or condition is specified in Exhibit A.

F

Your coverage does not include benefits for the following **Family planning** services:

- Services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including the drugs administered in connection with these procedures;
- Drugs used to treat infertility;
- Any services or supplies provided to a person not covered under this Plan Document in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);
- Non-prescription contraceptive devices; or
- Services to reverse voluntarily induced sterility.

Your coverage does not include benefits for services for palliative or cosmetic **foot** care including:

- Flat foot conditions;
- Support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
- Foot orthotics;
- Subluxations of the foot;
- Corns (except as treatment for patients with diabetes or vascular disease);
- Bunions (except capsular or bone surgery);
- Calluses (except as treatment for patients with diabetes or vascular disease);
- Care of toenails (except as treatment for patients with diabetes or vascular disease);
- Fallen arches;
- Weak feet;
- Chronic foot strain; or
- Symptomatic complaints of the feet.

H

Your coverage does not include benefits for **health club memberships**, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

Your coverage does not include benefits for **hearing aids** or for examinations to prescribe or fit hearing aids, unless otherwise specified in the Plan Document.

Your coverage does not include benefits for the following **Home Health Care Services**:

- Homemaker services (except as rendered as part of Hospice Care);
- Maintenance therapy;
- Food and home delivered meals; or
- Custodial Care and services.

Your coverage does not include benefits for the following **Hospital** services:

- Guest meals, telephones, televisions, and any other convenience items received as part of your Inpatient stay;
- Care by interns, residents, house Physicians, or other facility employees that are billed separately from the facility; or
- A private room unless it is Medically Necessary (Plan 8 Participants must have approval from the HMO).

I

Your coverage does not include benefits for **immunizations** required for travel and work, unless such services are received as part of the covered Preventive Care services as defined in the Covered Services section of this Plan Document.

M

Your coverage does not include benefits for **Medical equipment (durable), appliances, devices, and supplies** that have both a non-therapeutic and therapeutic use. These include but are not limited to:

- Exercise equipment;
- Air conditioners, dehumidifiers, humidifiers, and purifiers;
- Hypoallergenic bed linens, bed boards;
- Whirlpool baths;
- Handrails, ramps, elevators, and stair glides;
- Telephones;
- Adjustment made to a vehicle;
- Foot orthotics;
- Changes made to a home or place of business; or
- Repair or replacement of equipment you lose or damage through neglect.

Your coverage does not include benefits for **Medical equipment (durable)** that is not appropriate for use in the home.

Your coverage does not include benefits for services or supplies deemed not **Medically Necessary** by the HMO at its sole discretion. Notwithstanding this exclusion, all Preventive Care services and Hospice Care services described in this Plan Document are covered. This exclusion shall not apply to services you receive on any day of Inpatient Care that is determined by the HMO to be not Medically Necessary if such services are received from a Professional Provider who does not control whether you are treated on an Inpatient basis or as an Outpatient, such as a pathologist, radiologist, anesthesiologist or consulting Physician. Additionally, this exclusion shall not apply to Inpatient services rendered by your admitting or attending Physician other than Inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending Physician for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your admitting or attending Physician. Also, this exclusion shall not apply to the services rendered by a pathologist, radiologist, or anesthesiologist in an (i) Outpatient Hospital setting, (ii) Emergency room, or (iii) Ambulatory Surgical setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending Physician.

Nothing in this exclusion shall prevent a Covered Person from appealing the HMO's decision that a service is not Medically Necessary.

Your coverage does not include benefits for the following **mental health services and Substance Use Disorder services**:

- Inpatient stays for environmental changes;
- Cognitive rehabilitation therapy;
- Educational therapy;
- Vocational and recreational activities;
- Coma stimulation therapy;
- Services for sexual deviation and dysfunction;
- Treatment of social maladjustment without signs of psychiatric disorder;
- Remedial or special education services; or
- Inpatient mental health treatments that meet the following criteria:
 - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the Inpatient treatment program of the Hospital
 - group psychotherapy when there are more than 8 patients with a single therapist
 - group psychotherapy when there are more than 12 patients with two therapists — more than 12 convulsive therapy treatments during a single admission
 - psychotherapy provided on the same day of convulsive therapy

Your coverage does not include benefits for **Morbid Obesity** under Plan 8.

N

Your coverage does not include benefits for **nutritional and/or dietary supplements**, except as provided under this Plan Document or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

O

Your coverage does not include benefits for **organ or tissue transplants**, including complications caused by them, except as outlined in the Covered Services section of this Plan Document.

P

Your coverage does not include benefits for **paternity testing**.

Your **Prescription Drug** benefit does not cover:

- Over-the-counter drugs, except as specified in the Prescription Drugs section of this Plan Document;
- Any per unit, per month quantity over the specified limit;
- Drugs used mainly for cosmetic purposes;
- Drugs that are experimental, investigational, or not approved by the FDA, as described in Exhibit A;
- Cost of medicine that exceeds the Maximum Allowed Amount for that prescription;
- Drugs for weight loss;
- Therapeutic devices or appliances;
- Injectable Prescription Drugs that are supplied by a provider other than a pharmacy;
- Charges to inject or administer drugs;
- Drugs not dispensed by a licensed pharmacy;
- Drugs not prescribed by a licensed provider;
- Any refill dispensed after one year from the date of the original prescription order;
- Infertility medications;
- Medications used to treat sexual dysfunction;
- Medicine covered by workers' compensation, Occupational Disease Law, state or government agencies;
or
- Medicine furnished by any other drug or medical service.

R

Your coverage does not include benefits for rest cures, custodial, **residential**, or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily Physician visits, daily assessments, and structured therapeutic services.

S

Your coverage does not include benefits for **services, supplies or devices** if they are:

- Not listed as covered under this Plan Document;
- Not prescribed, performed, or directed by a provider licensed to do so;
- Received before the Effective Date or after a Covered Person's coverage ends;
- Telephone consultations, charges for not keeping appointments, charges for completing claim forms, other such charges;
- Services prescribed, ordered, referred by or received from a member of your immediate Family, including your spouse, child, brother, sister, parent, in-law, or self; or
- Benefits for charges from stand-by Physicians in the absence of Covered Services being rendered.

Your coverage does not include benefits for **services or supplies** if they are provided or available to a Covered Person:

- Under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefit plans offered to either civilian Employees or retired civilian Employees of the federal or state government.
- Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payor after benefits under this Plan Document have been paid.

This exclusion applies whether or not the Covered Person waives his or her rights under these laws, amendments, programs or terms of employment. However, the HMO will provide the Covered Services specified in this Plan Document, when benefits under these programs have been exhausted.

Your coverage does not include benefits for **services** for which a charge is not usually made. This includes services for which you would not have been charged if you did not have health care coverage.

Your coverage does not include benefits for:

- Amounts above the Maximum Allowed Amount for a service;
- Penile implants; or
- Neurofeedback and related diagnostic tests.

Your coverage does not include benefits for the following **Skilled Nursing Facility** stays:

- Treatment of psychiatric conditions and senile deterioration;
- Facility services during a temporary leave of absence from the facility; or
- A private room, unless it is Medically Necessary.

Your coverage does not include benefits for **smoking cessation** programs not affiliated with us.

Your coverage does not include benefits for the following **Spinal Manipulation and manual medical therapy services**:

- Any treatment or service not authorized by ASHN;

- Any treatment or service not provided by an ASHN provider (this exclusion does not apply to Point of Service plans);
- Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment;
- Laboratory tests, x-rays, adjustments, physical therapy or other services not documented as Medically Necessary and appropriate, or classified as experimental or in the research stage;
- Diagnostic scanning, including magnetic resonance imaging (MRI), CAT scans, and/or other types of diagnostic scanning; thermography;
- Educational programs, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing;
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; or
- Vitamins, minerals, nutritional supplements, or any other similar type products.

T

Your coverage does not include benefits for the following **therapies**:

- Physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children from birth to age three who qualify for Early Intervention services;
- Group speech therapy;
- Group or individual exercise classes or personal training sessions; or
- Recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

Your coverage does not include benefits for non-interactive **Telemedicine Services**. Non-interactive Telemedicine services include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

V

Unless specifically covered elsewhere in this Plan document, and any attachments hereto, your coverage does not include benefits for the following **vision** services:

- Vision services or supplies unless needed for vision correction after surgery or accident;
- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- Services for vision training and orthoptics;
- Tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental Injury;
- Sunglasses or safety glasses and accompanying frames of any type;
- Any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power;

- Any lost or broken lenses or frames;
- Any blended lenses (no line), oversize lenses, progressive multifocal lenses, photochromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses;
- Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; or
- Any other vision services not specifically listed as covered.

W

Your coverage does not include benefits for **weight loss programs**, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered under this Plan Document. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Your coverage does not include benefits for services or supplies if they are for **work-related** injuries or diseases, when the Employer must provide benefits by federal, state, or local law or when that person has been paid by the Employer. Services will not be covered if you could have received benefits for the Injury or disease if you had complied with applicable laws and regulations. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your Employer's procedures to receive the benefits. It also applies whether or not the Covered Person reaches a settlement with his or her Employer or the Employer's insurer or self-insurance association because of the Injury or disease.

Section 9 Coordination of Benefits

9.1 Coordination of Benefits (“COB”)

Special COB rules apply when you or members of your Family have additional health care coverage through other group health plans, including:

- Group insurance plans, including other Blue Cross and Blue Shield plans or HMO plans;
- Labor management trustee plans, union welfare plans, Employer welfare plans, Employer organization plans, or Employee benefit organization plans;
- Coverage under any tax-supported or government program to the extent permitted by law; and
- Coverage under any statute including no fault insurance coverage and personal injury protection.

9.2 Primary Coverage and Secondary Coverage

When a Covered Person is also enrolled in another group health plan, one coverage will pay benefits first (be primary) and the other will pay second (be secondary). The primary coverage will pay benefits first. The decision of which coverage will be primary or secondary is made using benefit determination rules. Highlights of these rules are described below:

- This Plan is always secondary to no fault auto insurance or personal injury protection insurance.
- If the other coverage does not have COB rules substantially similar to the HMO’s, the other coverage will be primary.
- If a Covered Person is enrolled as the named insured under one coverage and as a Dependent under another, generally the one that covers him or her as the named insured will be primary.
- If a Covered Person is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the Covered Person is enrolled as a child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the Calendar Year will be the primary.
- Special rules apply when a Covered Person is enrolled as a child under two coverages and the child’s parents are separated or divorced. Generally, the coverage of the parent or stepparent with custody will be primary. However, if there is a court order that requires one parent to provide for medical expenses for the child, that parent’s coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the Calendar Year will be primary.

When the HMO provides secondary coverage, we first calculate the amount that would have been payable had the HMO been primary. Then we coordinate benefits so that the combination of the primary plan’s payment and the HMO’s payment does not exceed the amount the HMO would have paid had it been primary. When the primary coverage provides benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the benefit payment.

The preceding paragraph does not apply to claims for Outpatient Prescription Drugs provided by a pharmacy when Medicare Part D provides the Covered Person’s primary Prescription Drug coverage. See the following section for more information.

9.3 How Prescription Drug Benefits are Coordinated When Medicare Part D is Primary

If Medicare Part D provides your primary coverage for Outpatient Prescription Drugs provided by a pharmacy, we first calculate the amount that would have been payable had the HMO been primary. We then pay a secondary benefit up to that amount, in order to reduce any amount you had to pay Out-of-Pocket under Medicare Part D. The benefit we pay is limited to the lesser of the amount you paid Out-of-Pocket under Medicare Part D or the amount the HMO would have paid if it had been primary.

Section 10 Coordination of Benefits with Medicare

10.1 Eligibility for Medicare

A Participant may have coverage under the Plan and under Medicare. Medicare means those benefits offered under Title XVIII of the Social Security Act, and includes all of the benefits provided by Parts A and B of Medicare. When a Participant has coverage under both the Plan and Medicare, the Plan will pay primary benefits for:

- An active Employee who is age 65 and over;
- An active Employee's covered spouse age 65 and over;
- An active Employee or covered Dependent of an active Employee under age 65 entitled to Medicare because of a Disability; or
- The first 30 months of treatment for End Stage Renal Disease received by any Participant, as set forth under the Medicare Secondary Payer Act, unless Medicare was already the primary payer for the Participant based on age or Disability prior to the End Stage Renal Disease diagnosis.

Note: The definition of active Participant for purposes of Medicare is different from the definition of Actively at Work or Employee for purposes of this Plan Document.

10.2 Election by Participant

A Participant, spouse, or Dependent who is covered under Medicare and the Plan, and who falls into the categories above, may elect to waive coverage under the Plan. If an individual waives coverage under the Plan, the Plan will no longer provide coverage for that person. If a Participant elects Medicare as the primary coverage, the Participant will have no further coverage under this Plan.

10.3 HCFA Regulation

This Section is based on regulations issued by the Health Care Financing Administration ("HCFA"), now known as Centers for Medicare and Medicaid Services ("CMS"), and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare Secondary Payer Rules. The Plan will coordinate with Medicare to the fullest extent permitted by applicable law. If the Plan in any way conflicts with regulations issued by CMS, the Plan will pay benefits in accordance with CMS regulations.

Section 11 Subrogation, Reimbursement and Third-Party Recovery

11.1 Benefits Subject to this Provision

This provision shall apply to all benefits provided under any section of this Plan. This provision applies to benefits provided to Participants and Dependents, COBRA beneficiaries, and any other person who may recover on behalf of a Covered Person or beneficiary – including, but not limited to, the Covered Person’s attorney, the parents, trustee, guardian or other representative of a minor Covered Person, and the estate of a deceased Covered Person or beneficiary, regardless of whether or not the representative has access or control of the Recovery.

11.2 When this Provision Applies

A Covered Person may incur medical or other charges related to Injuries or Illnesses caused by the act or omission of Another Party including a Doctor or other provider for acts or omissions including but not limited to malpractice; or Another Party may be liable or legally responsible for payment of charges Incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against Another Party for payment of the medical or other charges.

Benefits are payable only upon the Covered Person’s acceptance of the terms and conditions of this Plan. The Participant agrees that acceptance of benefits is constructive notice of this section.

The Plan’s subrogation right allows the Plan to pursue any claim that the Covered Person has against Another Party, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against Another Party, but in any event, the Plan has an equitable lien on any amount of the Recovery of the Covered Person whether or not designated as payment for medical expenses. Each Covered Person (and/or Covered Person’s attorney) agrees to hold any Recovery in constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid the reasonable value of any such benefit paid or payable to, or on behalf of the Covered Person.

11.3 Defined Terms

- **“Another Party”** shall mean any individual, corporation, or entity, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person’s Injuries or Illnesses. Another Party shall include the party or parties who caused the Injuries or Illness (first or third parties); the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person’s own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner’s, renter’s or any other liability insurer; a workers’ compensation insurer; a medical malpractice or similar vaccination or class action fund issue; and any other person, corporation or entity that is liable or legally responsible for payment in connection with the Injuries or Illness.
- **“Recovery”** shall mean any and all money, property, compensation or damages paid or available to the Covered Person by Another Party through insurance payments, settlement proceeds, first or third party payments or settlement proceeds, judgements, reimbursements or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness.
- **“Reimbursement”** or **“Reimburse”** shall mean repayment to the Plan for medical or other benefits paid or payable toward care and treatment of the Illness or Injury and for any other expenses Incurred by the Plan in connection with benefits paid or payable.

- **“Subrogation”** or **“Subrogate”** shall mean the Plan’s right to pursue the Covered Person’s claims against Another Party for medical or other charges paid by the Plan.

11.4 Subrogation

As a condition to receiving benefits under this Plan, including the payment of future benefits, a Covered Person (and/or the Covered Person’s attorney) agrees:

- To execute and deliver to the Plan Administrator a Subrogation and Reimbursement agreement within 30 days of the date of the initial claim. The Plan Administrator may determine, in its sole discretion, that it is in the Plan’s best interests to pay medical or other benefits for the Injuries or Illness before the Subrogation and Reimbursement agreement has been signed; however, in that event, the Plan will still be entitled to Subrogation and Reimbursement according to the terms of this Section;
- To refrain from releasing Another Party that may be liable for or obligated to the Covered Person for an Injury or Illness or condition without obtaining the Plan’s written approval; and
- Without limiting the preceding, that the Plan shall be subrogated to any and all claims, causes of action for rights that the Covered Person has or that may arise against Another Party for which the Covered Person claims an entitlement to benefits under this Plan, regardless of how classified or characterized.

The Covered Person shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim, including but not limited to completing questionnaire(s) regarding the claim or potential claim sent to the Covered Person by or on behalf of the Plan. If a requested Subrogation and Reimbursement Agreement is not executed and returned, or if information and assistance is not provided to the Plan Administrator upon request, the Plan Administrator, in its sole discretion, may deny claims for benefits with respect to costs incurred in connection with said Illness or Injury or terminate Plan coverage in its entirety for the Covered Person and any Dependents. A Covered Person’s termination of Plan coverage for the reasons set forth in this provision generally does not constitute a qualifying event within the meaning of COBRA.

If the Covered Person (or legal representative of the Covered Person, including the guardian or estate) decides to pursue a claim against a first or third party for any coverage or damages available to them as a result of the Injury or Illness, the Covered Person agrees to include the Plan’s subrogation claim in that action. If there is failure to do so, the Plan will be legally presumed to be included in such action or recovery. In the event the Covered Person decides not to pursue any and all claims against a first or third party for coverage or damages, the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claim in his or her name, to execute any and all documents necessary to pursue said claims in his or her name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person (or other legal representative of the Covered Person, including the guardian or estate) agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, and execute and deliver any acknowledgement and other legal instruments documenting the Plan’s subrogation rights. The Plan is responsible for only those legal costs that are related to the Plan’s decision to enforce its subrogation rights.

The Plan will not pay, offset any recovery, or in any way be responsible, without its written consent, for any fees, including attorney’s fees, or costs associated with a Covered Person or a legal representative of a Covered Person pursuing a claim against a first or third party for any coverage or damages available to them.

Regardless of how a claim, recovery or cause of action is classified or characterized by a party, a court or any other entity, such classification or characterization shall not impact the Covered Person’s responsibilities described above or the Plan’s entitlement to first-dollar recovery, regardless of whether the Covered Person is made whole. The Plan’s subrogation rights override the Covered Person’s rights to be made whole. This right of subrogation

shall bind the Covered Person, the Covered Person's guardian(s), estate, executor, personal representative, and heirs, COBRA beneficiaries and any other person who may recover on behalf of a Covered Person, including the Covered Person's attorney.

11.5 Reimbursement

As a condition to receiving benefits under this Plan, including the payment of future benefits, a Covered Person (and/or Covered Person's attorney) agrees:

- To execute and deliver to the Plan Administrator a Subrogation and Reimbursement agreement within 30 days of the date of the initial claim. The Covered Person's attorney must recognize and consent to the fact that the Plan precludes operation of the "made-whole" and "common fund" doctrines, and the attorney must agree to not assert either doctrine in his or her pursuit of Recovery. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injuries or Illness before the Subrogation and Reimbursement agreement has been signed; however, in that event, the Plan will still be entitled to Subrogation and Reimbursement according to the terms of this Section;
- To notify the Plan Administrator immediately in writing of any proposed settlement and obtain the Plan's written consent before signing a settlement agreement;
- To notify the Plan Administrator immediately in writing if any recovery is received by or on behalf of a Covered Person from Another Party that may be liable for or obligated to the Covered Person for an Injury or Illness or condition (without regard to admission of fault);
- To serve as a constructive trustee and to hold in constructive trust for the benefit of the Plan any Recovery, without regard to admission of fault, equal to the reasonable value of benefits paid or that will be paid by the Plan. The Covered Person agrees not to dissipate any such money or property without prior written consent of the Plan, regardless of how such money or property is classified or characterized or regardless of any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies or funds from which such money or property was received;
- To restore to the Plan the reasonable value of any such benefit paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by Another Party; and
- To refrain from releasing Another Party that may be liable for or obligated to the Covered Person for an Injury or Illness or condition without obtaining the Plan's written approval.

The Covered Person shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim, including but not limited to completing questionnaire(s) regarding the claim or potential claim sent to the Covered Person by or on behalf of the Plan. If a requested Subrogation and Reimbursement Agreement is not executed and returned, or if information and assistance is not provided to the Plan Administrator upon request, the Plan Administrator, in its sole discretion, may deny claims for benefits with respect to costs incurred in connection with said Illness or Injury or terminate Plan coverage in its entirety for the Covered Person and any Dependents. A Covered Person's termination of Plan coverage for the reasons set forth in this provision generally does not constitute a qualifying event within the meaning of COBRA.

The Plan will not pay, or in any way be responsible, without its written consent, for the Covered Person's or his/her legal representative's attorney's fees and costs associated with the recovery of funds or pursuit of a claim against a first or third party for any coverage or damages available to them, nor will it reduce its reimbursement pro rata for the payment of the Covered Person's or his/her legal representative's attorney's fees and costs. Attorneys' fees may be payable from the recovery only after the Plan has received full reimbursement.

An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this Section. A Covered Person's attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the Covered Person nor his attorney is the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

Regardless of how a claim, recovery or cause of action is classified or characterized by a party, a court or any other entity, such classification or characterization shall not impact the Covered Person's responsibilities described above or the Plan's entitlement to first-dollar recovery, regardless of whether the Covered Person is made whole. The Plan's reimbursement rights override the Covered Person's rights to be made whole. This right of reimbursement shall bind the Covered Person, Covered Person's guardian(s), estate, executor, personal representative, and heir(s), COBRA beneficiaries and any other person who may recover on behalf of a Covered Person, including the Covered Person's attorney.

If a Covered Person fails to reimburse the Plan for the reasonable value of benefits paid or to be paid, as a result of their Illness or Injury, out of any such recovery or reimbursement, the Covered Person (or the Covered Person's designee) will be liable for any and all expenses (including attorney's fees or costs) associated with the Plan's attempt to recover such amount from the Covered Person.

11.6 Constructive Trust

The Covered Person (and/or Covered Person's attorney), by accepting benefits under this Plan, agrees:

- To hold in constructive trust for the Plan's benefit any money or property resulting from any recovery, insurance payments or settlement proceeds, first or third party payments, settlement proceeds or judgment, without regard to admission of fault, and that the Plan has an equitable lien by agreement over any such recovery in an amount equal to the reasonable value of benefits paid or that will be paid by the Plan to the Covered Person under this Section; and
- The Covered Person further agrees to hold such amounts separately and without commingling with the Covered Person's (or the Covered Person's designee's) general assets.

The Covered Person acknowledges that the Plan has a property interest in the Covered Person's settlement, recovery, or reimbursement, and that the Plan's reimbursement rights shall be considered a first priority claim if the Plan pays primary and shall be paid before any other claims for the Covered Person as the result of the Injury or Illness, regardless of whether the Covered Person is made whole. If a Covered Person fails to reimburse the Plan for the reasonable value of benefits paid or to be paid, as a result of their Illness or Injury, out of any such recovery or reimbursement, the Covered Person (or the Covered Person's designee) will be liable for any and all expenses (including attorney's fees or costs) associated with the Plan's attempt to recover such amount from the Covered Person. This right of reimbursement shall bind the Covered Person, Covered Person's guardian(s), estate, executor, personal representative, and heir(s), COBRA beneficiaries and any other person who may recover on behalf of a Covered Person, including the Covered Person's attorney. A Covered Person's failure to observe the obligations in this provision may result in the termination of Plan coverage for the Covered Person, including any Dependents' coverage, in the Plan Administrator's sole discretion. A Covered Person's termination of coverage for the reasons set forth in this provision generally does not constitute a qualifying event within the meaning of COBRA.

Any amounts subject to a constructive trust under this section shall be limited to amounts received by the Covered Person or their legal representative for said Injury or Illness. Any recovery made by the Plan under this section shall be limited to the reasonable value of medical expenses and other fees and costs, including attorney's fees, paid by or payable by the Plan for said Injury or Illness.

11.7 Rights of Recovery

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment from the Covered Person or, if applicable, the provider or otherwise make appropriate adjustments to claims. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician or other provider of health care, and the payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

11.8 Right to Receive and Release Necessary Information

For the purpose of implementing the terms of this Plan, the Plan Administrator retains the right to request any medical information from any insurance company or other provider of service it deems necessary to properly process a claim in its sole discretion. The Plan Administrator may, in its sole discretion and without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Section 12

Claims and Payments

We consider the charge to be incurred on the date a service is provided. This is important because you must be actively enrolled on the date the service is provided. Various limits will be described in the associated SBCs and this section of the Plan Document.

12.1 Calendar Year Deductible

Your benefits may include a Calendar Year Deductible for Covered Services. Before we will make payments for certain Covered Services, you must first satisfy the Deductible (if any). See the associated SBCs and this section of the Plan Document for the amount of your Calendar Year Deductible and applicable services.

Covered Services received during the last three months of the Calendar Year that applied to a covered person's Deductible (if any), may also apply to the medical Deductible (excluding the prescription deductible) required for the following Calendar Year.

12.2 What You Will Pay

Copayments and Coinsurance (if any) for certain Covered Services are outlined in the associated SBCs. These amounts are your financial responsibility. Copayments should be paid by or on behalf of the Covered Person at the time the Covered Service is rendered. Applicable Deductible and/or Coinsurance may also be collected.

The associated SBCs may contain one Copayment which covers all prenatal and postnatal visits for each pregnancy. In most cases, this will be a more favorable benefit than paying the Specialist Copayment for each prenatal and postnatal visit. If, for any reason, your per-pregnancy Copayment exceeds the total Copayments you would have paid if you had paid your Specialist Copayment for each prenatal and postnatal visit, the HMO or the HMO Provider will reimburse you the difference between the per-pregnancy Copayment and the total per visit Specialist Copayments you would have paid for all prenatal and postnatal visits during any one pregnancy.

12.3 Calendar Year Out-of-Pocket Expense Maximums

Calendar Year limit

The associated SBCs lists the Calendar Year Out-of-Pocket Maximum for Copayments, Coinsurance or Deductible (if any). When a Covered Person reaches the annual Calendar Year Out-of-Pocket Maximum, that Covered Person will no longer be required to pay additional Copayments, Coinsurance or Deductible (if any) for the remainder of that Calendar Year.

The in-plan and Out-of-Plan Calendar Year Out-of-Pocket Maximums are separate and amounts applied to one do not apply to the other. When a Member reaches the in-plan Calendar Year Out-of-Pocket Maximum, that Member will no longer be required to pay additional Copayments, Coinsurance or Deductible (if any) for in-plan services for the remainder of that Calendar Year. If a Member reaches the Out-of-Plan Calendar Year Out-of-Pocket Maximum, that Member will no longer be required to pay additional Copayments, Coinsurance or Deductible (if any) for Out-of-Plan services for the remainder of that Calendar Year. However, when all Covered Persons in the same immediate Family satisfy their aggregate Calendar Year Out-of-Pocket Maximum, no Covered Person in that Family will be required to pay additional Copayments, Coinsurance or Deductible (if any) for the remainder of that Calendar Year. When Covered Persons have reached their Calendar Year maximums, they will be notified by the HMO within 30 days.

The Copayments, Coinsurance and Deductible (if any) for the services listed below are not counted toward the Calendar Year Out-of-Pocket Maximum and are never waived. Any Copayments, Coinsurance or Deductible (if any) paid in excess of the Calendar Year Out-of-Pocket Maximum, except those which are never waived, will be promptly refunded to you.

12.4 What Does Not Count Toward This Maximum

Copayments, Coinsurance and Deductible (if any) for the following services do not apply toward the Calendar Year Out-of-Pocket Maximum:

- Routine vision exams.
- Prescription Drugs under your Prescription Drug card benefit (under Plans 9-11, see the associated SBCs for additional information).

Any medical Deductible amounts (excluding the prescription deductible) carried forward from the prior Calendar Year do not apply toward the Calendar Year Out-of-Pocket Maximum.

Any charges over the HMO's Maximum Allowed Amount are not considered Copayments or Coinsurance and do not apply toward the Calendar Year Out-of-Pocket Maximum.

12.5 How Your HMO Pays a Claim

The Covered Services available under your Plan Document are to be used only by you and your covered Dependents. You may not give permission to anyone else (assign your right) to receive Covered Services under your coverage.

You may not assign your right to receive payment for Covered Services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not constitute a waiver of, or otherwise restrict, the HMO's right to direct future payments to you or any other individual or facility. Notwithstanding any provision in this Plan Document to the contrary, however, the HMO:

- Will reimburse directly any ambulance service provider to whom the Covered Person has executed an assignment of benefits; and
- Will reimburse a non-HMO Provider or facility directly for medical screening and stabilization services which were rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act.

12.6 Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by HMO Providers and non-HMO Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive. The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement the HMO will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Plan Document and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable Preauthorization, utilization management or other requirements set forth in your Plan Document.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible, Copayment or Coinsurance, if any. In addition, you may be responsible for paying any difference between the Maximum Allowed Amount and the provider's actual charges. This amount can be significant.

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

12.7 Maximum Allowed Amount for Multiple Procedures

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

12.8 Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the provider is a HMO Provider or a non-HMO Provider. An HMO Provider is a provider who is in the HMO Network. For Covered Services performed by an HMO Provider, the Maximum Allowed Amount for this Plan is the rate the provider has agreed with us to accept as reimbursement for the Covered Services. Because HMO Providers have agreed to accept the Maximum Allowed Amount as payment in full for that service, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay a portion of the Maximum Allowed Amount if you have not met your Deductible, Copayment or Coinsurance if any. Please call Member Services for help in finding an HMO Provider or look on www.anthem.com.

Certain Covered Services such as medical supplies, ambulance, early intervention services, Home Health Care Services, private duty nursing, Medical equipment, and medical formulas, may be rendered by persons or entities that are not providers. There may or may not be networks established for these persons or entities. The Maximum Allowed Amount for services from these persons or entities will be determined in the same manner as described above for providers. For Prescription Drugs and diabetic supplies rendered by a pharmacy, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by our pharmacy benefits manager.

Providers who are not in the *HMO* Network are non-HMO Providers. When *you* receive *Covered Services* from a non-HMO Provider the *Maximum Allowed Amount* will be one of the following as determined by us:

1. An amount based on *our* non-HMO Provider fee schedule/rate, which *we* have established in *our* discretion, and which *we* reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar providers, reimbursement amounts paid by the Center for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on the level and/or method of reimbursement used by the Center for Medicare and Medicaid Services for the same services or supplies; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care, or
4. An amount negotiated by *us* or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through Case Management, or
5. An amount equal to the total charges billed by the provider, but only if such charges are less than the *Maximum Allowed Amount* calculated by using one of the methods described above.

Unlike *HMO Providers*, non-HMO Providers may send *you* a bill and collect for the amount of the provider's charge that exceeds *our Maximum Allowed Amount*. *You* are responsible for paying the difference between the *Maximum Allowed Amount* and the amount the provider charges. This amount can be significant. Please call Member Services for help in finding a *HMO Provider* or visit *our* website at www.anthem.com.

12.9 Covered Person Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance). Your cost share amount and Out-of-Pocket Maximums may vary depending on whether you received services from an HMO or non-HMO Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using non-HMO Providers. Please see the associated SBCs for your cost share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of provider you use.

The HMO will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your provider for non-Covered Services, regardless of whether such services are performed by an HMO or non-HMO Provider. Both services specifically excluded by the terms of your policy/Plan and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

12.10 Non-Participating Providers and Facilities

If you go to a non-Participating Provider or facility with the proper authorization, we may choose to pay you or anyone else responsible for paying the bill. We will pay only after we have received an itemized bill or proof of loss and all the medical information we need to process the claim. We reserve the right to pay no more for a service you receive from a non-Participating Provider or facility than we would have paid a Participating Provider or facility for the same service.

In the event that payment is made directly by you, you have the responsibility to apply this payment to the claim from the non-HMO Provider. In all cases, our payment relieves the HMO of any further liability for the service.

12.11 When You Must File a Claim

Most claims will be filed for you by HMO Providers. You may have to file a claim if you receive care out-of-area from a provider who is not an HMO Provider.

In most cases, the HMO will reimburse you for Covered Services paid for by you only if a completed claim (including receipt) has been received by the HMO within 180 days of the date you received such services.

If you receive Out-of-Plan services, you must submit your claims within 180 days from the date services are received. Claims will not be processed and will be denied if they are submitted more than 180 days from the date of service, except in the absence of legal capacity of the Member.

You will have to file a claim if you receive care billed by someone other than a Doctor or Hospital, or if the provider cannot file a claim for you. To file a claim, follow these 3 steps:

1. Call 833-597-2358 to order a claim form. You can also download a claim form at your www.anthem.com member self-service portal.
2. Complete and sign the claim form. Attach all itemized bills for Covered Services. Each itemized bill must contain the following:
 - o Name and address of the person or organization providing services or supplies;
 - o Name of the patient receiving services or supplies;
 - o Date services or supplies were provided;
 - o The charge for each type of service or supply;
 - o A description of the services or supplies received; and
 - o A description of the patient's condition (diagnosis).
3. Send the completed claim form and itemized bill(s) to:

HealthKeepers, Inc.
Attention: Operations
P. O. Box 26623
Richmond, VA 23261-6623

12.12 Recovery of Overpayments

The HMO shall have the right to recover any overpayment of benefits from persons or organizations that the HMO has determined to have realized benefits from the overpayment:

- Any persons to or for whom such payments were made;
- Any insurance company;
- A facility or provider; or
- Any other organization.

You will be required to cooperate with us to secure the HMO's right to recover the excess payments made on your behalf, or on behalf of covered persons enrolled under your Family coverage.

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

12.13 Complaint Process

In order to remain responsive to Participant's needs, the Plan has established both a complaint process and an appeal process. Complaints typically involve issues such as dissatisfaction about the Plan's services, quality of care, the choice of and accessibility to the HMO Providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by the HMO. Complaints may be registered by telephone or in writing. Upon receipt, the complaint will be reviewed and investigated. The Participant will receive a response within 30 calendar days of the Plan's receipt of the complaint. If the Plan is unable to resolve the complaint in 30

calendar days, the Participant will be notified on or before calendar day 30 that more time is required to resolve the complaint. The Plan will then respond within an additional 30 calendar days.

Complaints made over the phone may be made to Member Services using the phone number on the back of the Participant's identification card.

Complaints made in writing may be delivered to the following address:

Tim Klopfenstein, Executive Director
Virginia Private Colleges Benefits Consortium, Inc.
118 East Main Street
P.O. Box 1005
Bedford, VA 24523

12.14 Claims Procedures

There are different types of claims that can be made under the Plan, each with somewhat different claim and appeal rules. If you have any questions regarding what type of claim and/or what claims procedure to follow, please contact Member Services.

12.14.1 Types of Claims and Timeframes for Deciding Initial Claims

- **Pre-Service Claims** are claims for a service that require the Covered Person to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If the Covered Person calls to receive authorization for a service when Preauthorization is not required, the claim will be considered a Post-Service Claim. As outlined in Section 3, the Preauthorization process, the Plan will make Pre-Service Claims decisions within 15 days from the receipt of the request.
- **Post-Service Claims** are all claims other than Pre-Service, Urgent Care Claims, or Concurrent Care/Ongoing Course of Treatment Claims. Post-Service Claims include claims filed after services are rendered and claims that do not require Preauthorization of the service, even where the Covered Person requests Preauthorization. The Plan will make Post-Service Claims decisions within a reasonable time, but no later than 30 days and may be extended for another 15 days if it is determined to be necessary because of matters beyond Member Services control.
- **Urgent Care Claims** are claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's Physician, would subject the patient to severe pain. The Plan will defer to the patient's Physician as to whether a claim involves urgent care. As outlined in Section 3, the Preauthorization process, the Plan will make Urgent Care Claims decisions within 72 hours after receipt of the Claim. In cases where a Hospital admission is an Urgent Care Claim, a decision will be made within 24 hours and the Participant's Doctor will be notified verbally of the decision within this time frame.
- **Concurrent Care Claims/ Ongoing Course of Treatment Claims** are claims where the Plan approves an ongoing course of treatment to be provided over a period of time for a specified number of treatments. There are two types of Concurrent Care Claims: (a) where reconsideration of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments. As outlined in Section 3.6, Approvals of Care Involving an Ongoing Course of Treatment, the Plan will make Concurrent Care Claims decisions to extend a previously approved course of treatment within 24 hours of the request, when the request is made at least 24 hours prior

to the end of the authorized time frame to avoid disruption of care or services. Please see Section 3.6, for more information.

In processing the Participant's claim, the Plan may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the "When You Must File a Claim" paragraph of this Section will be processed within 30 days of receipt of the claim. This period may be extended for another 15 days if it is determined to be necessary because of matters beyond Member Services control. In the event that this extension is necessary, the Participant will be notified prior to the expiration of the initial 30-day period. If the decision involves a determination of the appropriateness or Medical Necessity of Services, Member Services will make a decision within 2 working days of the receipt of the medical information needed to process the claim.

12.14.2 Notification of Initial Benefit Decision

The Plan may deny a claim for Benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by the Participant or the Participant's provider by furnishing the additional information. The Participant or the Participant's provider must submit the additional information to us within either 15 months of the date of service or 45 days from the date the Participant was notified that the information is needed, whichever is later. Once the Participant's claim has been processed by the Plan, the Participant will receive written notification of the decision. In the event of an Adverse Benefit Determination, notice will be provided to the Participant in a culturally and linguistically appropriate format that is calculated to be understood by the Participant. The written notification will include the following:

- Information sufficient to allow the Participant to identify the claim involved (including the date of service, the healthcare provider, the claim amount, and, if applicable, the treatment code and its corresponding meaning);
- The specific reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- Reference to the specific Plan provisions on which the determination was based;
- A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external appeal procedures. This description will include information on how to initiate the appeal and the time limits applicable to such procedures. This will include a statement of the Participant's right to bring a civil action following a Final Adverse Benefit Determination;
- If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the Participant upon request;
- If the Adverse Benefit Determination is based on the Medical Necessity or experimental nature of the care or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request; and

- Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and External Review process.

If all or part of a claim was not covered, the Participant has a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the Plan relied upon in making the coverage decision. If a decision was based on Medical Necessity or the experimental nature of the care, the Participant is entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to Participant's medical condition.

12.15 Appeal Procedures

The Plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions the Participant finds unacceptable, whether the decision is a claim denial or a rescission of coverage. A rescission is a retroactive termination of coverage, other than when it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. The Plan will not make decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to claims adjudicators or medical experts based upon the likelihood that such individuals will support or tend to support a denial of benefits.

Internal appeals are requests to reconsider rescissions or coverage decisions of Pre-Service or Post-Service Claims. Expedited appeals of Urgent Care Claims are made available when the application of the time period for making Pre-Service or Post-Service appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's Physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain.

12.16 First Level of Appeal – Internal Appeals

To appeal a medical or pharmacy coverage decision, including a rescission, the Participant should send a written explanation of why the Participant feels the coverage decision was incorrect. The Participant or the Participant's authorized representative acting on the Participant's behalf must submit the written explanation. Alternatively, this information may be provided to a Member Services representative over the phone. This is the Participant's opportunity to provide any comments, documents, or information that the Plan should consider when reviewing the appeal. Please include with the explanation:

- The patient's name, address and telephone number;
- The Participant's identification and group number (as shown on the Participant's identification card); and
- In the case of a claim, the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

Important: For appeals, Participants should contact Member Services at the following address:

In Writing:

Anthem Blue Cross and Blue Shield
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

By Telephone:

833-597-2358

Appeals must be filed within either 15 months of the date of service or 180 days of the date the Participant was notified of the Adverse Benefit Determination, whichever is later.

12.16.1 Expedited Appeals of Urgent Care Claims

In light of the expedited timeframes for deciding of Urgent Care Claims, a Participant that wants to appeal an Urgent Care Claim should contact Member Services at the number shown on the back of the Participant's identification card and provide at least the following information:

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

12.17 Action on Appeal

In reviewing an appeal, the Plan will take into account all the information submitted, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing the appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff. The Plan will resolve and respond in writing to the appeal within the following time frames:

- For Pre-Service Claims, the Plan will respond in writing within 30 days after receipt of the request to appeal;
- For Post-Service Claims and rescissions, the Plan will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals of Urgent Care Claims, the Plan will respond to the Participant and the Participant's provider as soon as possible taking into account the medical condition, but not later than 72 hours from the receipt of the request.

The Plan will also provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim. In addition, before the Participant receives an Adverse Benefit Determination based on new or additional rationale, the Plan will provide the Participant, free of charge, with the rationale to give the Participant a reasonable opportunity to respond.

When the review of the appeal has been completed, the Participant will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the Plan provision(s) on which the determination is based; this written notification is the final Adverse

Benefit Determination. The Participant will also be entitled to receive, upon request and at no charge, the following:

- Reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- Any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- The explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- The identification of medical or vocational experts whose advice was obtained by the Plan in connection with the claimant's Adverse Benefit Determination, whether or not the advice was relied upon.

12.18 Second and Final Level of Appeal – External Review

If the outcome of the appeal is adverse to the Participant, the Participant may be eligible for an independent external review pursuant to federal law. The Participant must submit a request for external review to the Plan within 4 months of the notice of the final Adverse Benefit Determination. A request for external review must be in writing unless the Plan determines that it is not reasonable to require a written statement. The Participant does not have to re-send the information that was submitted as part of the internal appeal. However, the Participant is encouraged to submit any additional information that might be important for review.

Expedited external review requests are to be initiated by telephone

For Urgent Care Claims or Concurrent Care/ Ongoing Course of Treatment Claims, the Participant may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. The Participant or the Participant's authorized representative may formally request it orally or in writing, but in order to support the fastest review the Participant must call Member Services. All necessary information, including the Plan's decision, can be sent between the Plan and the Participant by telephone, facsimile or other similar method. To start an expedited external review, the Participant or the Participant's authorized representative must contact the Plan at the Member Services number shown on the back of the Participant's identification card and provide at least the following information:

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

Other external review requests

All other requests for external review should be submitted in writing unless the Plan determines that it is not reasonable to require a written statement. Such requests should be submitted by the Participant or the Participant's authorized representative to:

Tim Klopfenstein, Executive Director
Virginia Private Colleges Benefits Consortium, Inc.
118 East Main Street
P.O. Box 1005
Bedford, VA 24523

The Participant's decision to seek external review will not affect the Participant's rights to any other benefits under this health care Plan. There is no charge for the Participant to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

12.19 Timeframe for Deciding Benefit Appeals

The Named Fiduciary shall decide the appeal within the same timeframe as set forth in Sections 12.13 above.

12.20 Decision by the Named Fiduciary

The decision of the Named Fiduciary will be final and binding and will only be subject to review if such decision was arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Named Fiduciary shall be based only on such evidence presented to or considered by the Named Fiduciary at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decision that the Named Fiduciary makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described in this Section.

12.21 Notice in Writing

Any legal notice given to the Plan must be in writing and delivered to: Tim Klopfenstein, Executive Director, Virginia Private Colleges Benefits Consortium, Inc., 118 East Main Street, P.O. Box 1005, Bedford, VA 24523. The Plan will not be able to act on this notice unless the Participant's name and identification number are included in the notice. Notice by you is considered "given" when actually received by the Plan.

Notice given to a Covered Person will be sent to the Covered Person's address as it appears in the Plan's records. A Covered Person may provide a new address for giving notice by contacting the Plan Administrator in writing; by contacting the Human Resources Department; or, for employees who have direct access to the Plan's enrollment web-portal, by updating the address in the enrollment web-portal. A notice sent to you by the Plan is considered "given" when mailed to the Participant's last known address as shown in the Plan's enrollment records. Notices include any information which the Plan may send you, including identification cards.

12.22 Administrative Record

In any action for the recovery of benefits, the evidence which may be submitted for review shall be limited to the administrative record on the claim or appeal. Participants may not submit new arguments or theories of recovery in litigation.

12.23 Time Limits on Legal Action

No legal action on a claim may be brought against Anthem, IngenioRx, the Plan or the VPC Benefits Consortium until all appeal rights with respect to the claim have been exhausted. No legal action on a claim may be brought more than one year following the date that all appeal rights with respect to the claim have been exhausted. This limit applies to matters relating to this Plan, to our performance under this Plan, or to any statement made by an Employee, officer, or director of Anthem or IngenioRx concerning this Plan or the benefits available to a Covered Person.

12.24 Failure to File an Appeal

The Plan's internal appeals procedure (but not an external review) must be exhausted before filing a lawsuit or taking other legal action of any kind against the Plan. The Plan is subject to the Employee Retirement Income

Security Act of 1974 (ERISA). If an appeal, as described above, results in an Adverse Benefit Determination, the claimant has a right to bring a civil action under Section 502(a) of ERISA. The Plan reserves the right to modify the policies, procedures and time frames in this section upon further clarification from Department of Health and Human Services and Department of Labor.

12.25 Administrative Exhaustion Requirement

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought including a claim for benefits or for breach of fiduciary duty.

The Plan's internal appeals procedures can be deemed exhausted, however, and the claimant will be permitted to proceed to external review or judicial review, if the Plan fails to strictly adhere to the internal claims and appeals processes set forth in this Section.

The internal claims and appeals processes, however, will not be deemed exhausted if the Plan's noncompliance was (1) de minimis; (2) non-prejudicial; (3) attributable to good cause or matters beyond the Plan's control; (4) in the context of an ongoing good-faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. Upon written request, the Plan will, within 10 days, include a specific description of the bases for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If the external reviewer or the court rejects the claimant's request for immediate review (based on a finding that the Plan met this standard) the Plan will provide the claimant notice of the opportunity to resubmit and pursue the internal appeals of the claims. The notice will be sent within a reasonable time after the external reviewer rejects the claims for immediate review, but not later than 10 days.

12.26 Limitations of Damages

In the event a Covered Person or his representative sues Anthem, IngenioRx, the Plan or the VPC Benefits Consortium, or any of its directors, officers, or Employees acting in his or her capacity as director, officer, or Employee, for a determination of what coverage and/or benefits, if any, exist under this Plan, the damages shall be limited to the amount of the Covered Person's claim for Benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed.

12.27 The Plan's Continuing Rights

On occasion, the Plan may not insist on the Participant's strict performance of all terms of this Plan. This does not mean the Plan gives up any future rights it has under this Plan.

12.28 The HMO's Relationship to Providers

The choice of an HMO Provider is solely the Covered Person's choice. HMO Providers are neither Employees nor agents of the HMO. We can contract with any appropriate provider or facility to provide services to you. Our inclusion or exclusion of a provider or a covered facility is not an indication of the provider's or facility's quality or skill. We make no guarantees about the healthcare provided by any HMO Providers. We do not furnish Covered Services, but only make payment for them when received by Covered Persons. Anthem, IngenioRx, the Plan and the VPC Benefits Consortium are not liable for any act or omission of any provider, nor is Anthem, IngenioRx, the Plan or the VPC Benefits Consortium responsible for a provider's failure or refusal to render services to a Covered Person.

12.29 Assignment of Payment

A Covered Person may not assign the right to receive payment for services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not waive or otherwise restrict the Plan's or the VPC

Benefits Consortium's right to direct future payments to a Covered Person or any other entity. This provision does not apply to Dentists and oral surgeons.

Once services are rendered by a provider, the Plan, the VPC Benefits Consortium and payers contracted by the Plan or the VPC Benefits Consortium will not honor requests not to pay the claims submitted by the provider. The Plan, the VPC Benefits Consortium and payers contracted by the Plan or the VPC Benefits Consortium will have no liability to any person because it rejects the request.

12.30 Special Limitations

The rights of Covered Persons and obligations of the HMO are subject to the following special limitations: To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other Emergency or similar event not within the control of the HMO results in the facilities, personnel, or financial resources of the HMO being unavailable to provide or arrange for the provision of Covered Services, the HMO shall make a good faith effort to provide or arrange for the provision of such health services taking into account the impact of the event. In such an event, the HMO and HMO Providers shall render covered Hospital and medical services insofar as practical, and according to their best judgment. The HMO and HMO Providers shall incur no liability or obligation for delay, or failure to provide or arrange for health services if such failure or delay is caused by such an event.

Section 13 Statement of ERISA Rights

Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Participants shall be entitled to:

13.1 Receive Information About Participant's Plan and Benefits

Participants may examine, without charge, at the Plan's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Participants may obtain, upon written request to Tim Klopfenstein, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The VPC Benefits Consortium may make a reasonable charge for the copies.

Participant may receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the VPC Benefits Consortium is required by law to furnish each Participant with a copy of this summary annual report.

13.2 Enforce Participant's Rights

If Participant's claim is denied or ignored, in whole or in part, Participant has the right to know why this was done, to obtain copies of document relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Covered Person can take to enforce his or her rights. For instance, if a request for Plan documents is made to the Plan Administrator and such requested information is not received within 30 days, Participant may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until such requested information is received by the requesting Covered Person, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. Additionally, if a claim for benefits is denied or ignored, in whole or in part, and if Participant has exhausted the claims procedures available to Participant under the Plan as described in Section 12, Participant may file suit in federal court.

13.3 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate Participant's Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Participant and other Plan Participants and beneficiaries. No one, including Participant's Employer or any other person, may fire Participant or otherwise discriminate against Participant in any way to prevent Participant from obtaining a Plan benefit or exercising Participant's rights under ERISA.

If it should happen that Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his or her rights, then such Participant may seek assistance from the U.S. Department of Labor, or file suit in federal court. The court will decide who should pay court costs and legal fees. If a Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order such Covered Persons to pay these costs and fees, for example, if the court finds the claim is frivolous.

13.4 Questions

If Participant has any questions about the Plan, Participant should contact the VPC Benefits Consortium. If Participant has any questions about this statement, or about their ERISA rights, or if they need assistance in obtaining documents from the Plan Administrator, Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20220. Participant may also obtain certain publications about Participant's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 14 General Provisions

14.1 Verification

The Plan Administrator shall be entitled to require reasonable information to verify any Claim or the status of any person as a Covered Person. If the Covered Person does not supply the requested information within the applicable time limits or provide a release for such information, such Covered Person shall not be entitled to benefits under the Plan.

14.2 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against a Covered Person, the Board of Directors of the Association, any of their Employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related Trust, except as expressly provided herein or as provided by law.

14.3 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

14.4 Captions

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall the captions affect the Plan or the construction of any provision thereof.

14.5 Construction

Any words herein used in the masculine shall also include the feminine and neutral where they would so apply. Words in the singular shall also include the plural and vice versa where they would so apply.

14.6 Entire Plan

This document and the associated SBCs constitutes the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing.

14.7 Non-Guarantee of Employment

Nothing contained in the Plan shall be construed as a contract of employment between a Member and any Participant, or as a right of any Participant to be continued in the employment of a Member, or as a limitation of the right of a Member to discharge any of the Participants, with or without cause.

14.8 Governing Law

This Plan Document shall be governed by and construed and enforced with the laws of the Commonwealth of Virginia, to the extent not preempted by ERISA or other federal law.

14.9 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the IRS, we inform Participant that to the extent this communication (including any attachments) contains advice relating to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of (i) avoiding any penalties that may be imposed on Participant or any other person or entity under the Internal Revenue Code; or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein. If Participant is not the original addressee of this communication, Participant should seek advice from an independent advisor based on the particular circumstances.

Section 15
Plan Administrator Duties and Powers

15.1 Appointment of Plan Administrator

The VPC Benefits Consortium shall appoint a Plan Administrator to administer the Plan and keep records of proceedings and Claims. The Plan Administrator will serve until resignation or dismissal by the VPC Benefits Consortium. Any vacancy or vacancies shall be filled in the same manner as the original appointments. The VPC Benefits Consortium may dismiss any person or persons serving as Plan Administrator at any time with or without cause. In the event the VPC Benefits Consortium chooses to appoint more than one person to act as Plan Administrator, a majority vote of such shall be necessary for the transaction of business. In the event 2 persons are named as Plan Administrator, the transaction of business shall require the unanimous vote of both parties.

15.2 Powers of Plan Administrator

Subject to the limitations of the Plan, the Plan Administrator will from time to time establish rules for the administration of the Plan and transaction of its business. The Plan Administrator will rely on the records of the Members with respect to any and all factual matters dealing with the employment and eligibility of an Employee. The Plan Administrator will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions hereunder, including, but not limited to, the sole and absolute discretion to:

- Construe and interpret the Plan;
- Decide the questions of eligibility to participate in the Plan; and
- Determine the amount, manner and time of payment of any benefits to any Covered Person.

The Plan Administrator will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding.

15.3 Outside Assistance

The Plan Administrator may employ such counsel, accountants, Claims Administrators, consultants, actuaries and other person or persons, as the Plan Administrator shall deem advisable. The VPC Benefits Consortium shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan.

15.4 Delegation of Powers

In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable the Plan Administrator to properly carry out such duties. The Plan Administrator as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the Plan other than expressly provided in this Section.

Section 16
Amendments, Terminations and Mergers

16.1 Right to Amend, Merge or Consolidate

The VPC Benefits Consortium reserves the right to merge or consolidate the Plan, and to make any amendment or amendments to the Plan from time-to-time, including those which are retroactive in effect. Such amendments may be applicable to any Covered Person.

Any amendment shall be deemed to be duly executed by the VPC Benefits Consortium when approved by the Board of Directors. This approval shall be drafted in a Board Resolution that is to be signed by either the President or Vice-President, and attested by the Secretary or Treasurer.

16.2 Right to Terminate

The Plan is intended to be permanent, but the VPC Benefits Consortium may at any time terminate the Plan in whole or in part.

16.3 Effect on Benefits

Except as may otherwise be provided by applicable law or this Plan Document, if the Plan is amended or terminated, Covered Persons may not receive benefits described in the Plan after the Effective Date of such amendment or termination. Any such amendment or termination shall not affect a Covered Person's right to benefits for claims incurred prior to such amendment or termination. If the Plan is amended, Covered Persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA or other continuation benefits. This may happen from time to time. If the Plan is terminated, Covered Persons will not be entitled to any vested rights under the Plan.

Section 17 Covered Person Rights and Responsibilities

Successful relationships take a strong commitment from all sides—with each side recognizing the rights and responsibilities of the other. Your health care is no different. It takes strong team work between you, your health care professionals, and Anthem for coverage you can count on. Below is a statement of rights and responsibilities that guide our relationship with you. Please read through them, and should you have any questions, don't hesitate to give us a call.

17.1 We are Committed to:

- Recognizing and respecting you as a Covered Person.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our Network providers.
- Sharing our expectations of you as a Covered Person.

17.2 You Have the Right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our Network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your Physicians and providers appropriate or Medically Necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's Covered Persons' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your Physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a Doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- For assistance at any time, contact your local insurance department: by phone in Richmond (804) 371-9741, from outside Richmond (800) 552-7945, or in writing: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218.

17.3 You Have the Responsibility to:

- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your Doctor, and call the Doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers, in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Member Services Department know if you have any changes to your name, address, or Family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit Plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our Covered Persons. Benefits and coverage for services provided under the benefit program are governed by this Plan Document, and not by this Covered Person Rights and Responsibilities statement.

Glossary

The following terms, as used in the Plan, shall have the meaning specified in this Glossary, unless a different meaning is clearly required by the context in which it is used:

Actively at Work shall mean performing the Employee's job at the location where the Employee generally reports to work. If such Employee is on vacation, Approved Leave of Absence, Approved Sabbatical, Approved Disability Leave, or is off due to a holiday or other reason approved by the Employer, the Employee will be deemed Actively at Work if the Employee was Actively at Work on the day immediately prior to the vacation, Approved Leave of Absence, Approved Sabbatical, Approved Disability Leave, holiday or other Employer-approved reason.

Activities of Daily Living shall refer to the following, with or without assistance:

- Bathing, which is the cleansing of the body in either a tub, shower or by sponge bath;
- Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting, which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
- Transferring, which is to move in and out of a bed, chair, wheelchair, tub or shower;
- Mobility, which is to move from one place to another, with or without the assistance of equipment;
- Eating, which is getting nourishment into the body by any means other than intravenous; and
- Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

Adverse Benefit Determination means a claim that is denied, in whole or in part, or if Plan coverage is rescinded retroactively on the basis of fraud or misrepresentation.

Ambulatory Care shall mean services provided in an Ambulatory Care Facility.

Ambulatory Care Facility shall mean a facility that provides Outpatient Care.

Ambulatory Surgical Facility shall mean an ambulatory surgical center, free-standing surgical center, or Outpatient surgical center, which is not part of a Hospital and which:

- Has an organized medical staff of Doctors;
- Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- Has continuous Doctor's services and registered nursing (R.N.) services whenever a patient is in the facility;
- Is licensed by the jurisdiction in which it is located; and
- Does not provide for overnight accommodations.

Applied Behavioral Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Approved Disability Leave shall mean an approved leave for purposes of Disability for the period of time approved and designated by the Member as a short-term disability leave for the Employee for a period not to exceed one year. For purposes of this Section, the term “Disability” shall mean that the Employee is not able to perform the duties of the Employee’s regular occupation with the Member, as determined in the sole discretion of the Plan Administrator.

Approved Leave of Absence shall mean an Approved Leave of Absence for a period not to exceed 12 consecutive months, with the stated intention of returning to full time employment with the Member. For purposes of this document the term Approved Leave of Absence shall not refer to leave under the Family and Medical Leave Act.

Approved Sabbatical shall mean an approved paid sabbatical or fellowship for a period not to exceed 12 consecutive months. Participant must be covered prior to Effective Date of Leave.

Attained Age shall mean the age in years of a Covered Person as of the last anniversary of his date of birth.

Bariatric Surgery shall have the same meaning as set forth in the VPC Benefits Consortium Bariatric Surgery Policy, available from the Plan Administrator.

Calendar Year shall mean January 1 to December 31 of each year.

Case Management is a program in which a case manager monitors the Covered Person to explore and/or discuss alternative or other coordinated types of Medical Care available.

Claims Administrator shall mean the person or persons appointed by the Plan Administrator to determine benefit eligibility and to adjudicate claims under the Plan.

COBRA shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Coverage or Continuation Coverage shall mean the continuation of health care benefits for Participants and Dependents on the occurrence of a Qualifying event as defined by COBRA, and as further set forth in the Continuation of Coverage Section.

Code shall mean the Internal Revenue Code of 1986, as amended.

Coinsurance is the percentage of the Maximum Allowed Amount that you pay for some Covered Services.

Complications of Pregnancy shall mean:

- Conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, abortion where the life of the mother is endangered and complications of abortion and similar medical and surgical conditions of comparable severity;
- Non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Concurrent Care Claims/ Ongoing Course of Treatment Claims shall mean claims where the Plan approves an ongoing course of treatment to be provided over a period of time for a specified number of treatments. There are two types of Concurrent Care Claims: (a) where reconsideration of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments.

Congenital Defects shall mean newborn coverage including coverage for Injury or Illness, and the necessary care or treatment of medically diagnosed Congenital Defects, birth abnormalities, anomalies, including cleft lip or cleft palate or prematurity.

Continuation Coverage Payments shall mean the payments required for COBRA Continuation Coverage.

Copayment shall mean the Covered Person's portion of the payment for certain Covered Services indicated in the associated SBCs. This payment may be requested at the time of service. Copayments do not count toward the satisfaction of Deductibles or Out-of-Pocket Maximums.

Cosmetic Treatment or Surgery shall mean medical or surgical procedures to alter normal structures of the body in order to improve appearance, treat a Mental Health Disorder or to improve self-esteem.

Covered Person shall mean a Participant or Dependent covered under the Plan.

Covered Services shall mean those services listed as covered in the Covered Services Section 7.

Custodial Care shall mean non-medical aid consisting of services and supplies, provided to an individual in or out of an institution, primarily to assist such person in Activities of Daily Living, whether or not disabled.

Deductible is a fixed dollar amount of Covered Services you pay in the Calendar Year before the Plan will pay for certain benefits as specified in the applicable associated SBCs.

Dentist shall mean an individual licensed as a Dental Practitioner in the jurisdiction where services are provided.

Dependent shall mean any person described below who is:

- **Spouse.** The legally recognized spouse of a Participant, provided that a spouse that is legally separated or divorced from the Participant shall not be a Dependent, except for purposes of COBRA Continuation Coverage.
- **Child.** A child up to the end of the Plan Year when such child attains age 26, who is:
 - A natural child;
 - A legally adopted child, which shall be defined as a child adopted or placed for adoption with the Participant or the Participant's spouse. The child's placement for adoption ends upon the termination of the legal obligation;
 - A stepchild;
 - A child of a Participant required to be covered in accordance with applicable requirements of any Qualified Medical Child Support Order as defined by ERISA Section 609; or
 - A child with proof of legal guardianship for whom the Participant or the Participant's spouse is the court-appointed legal guardian.
- **Disabled Child.** A child, as defined above, regardless of age, who is incapable of self-sustaining employment due to a severe physical or mental condition that is expected to last indefinitely and who is dependent on a Participant or a Participant's Spouse for support and maintenance. If written proof of such incapacity and dependency satisfactory to the Plan is furnished to and approved by the Plan within thirty-one (31) days after the date the Disabled Child's coverage would otherwise terminate due to attaining age 26, the Disabled Child will remain a Covered Dependent and coverage will continue beyond the date the Disabled Child attains age 26, provided that the child continues to qualify as a Disabled Child and a Dependent. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan. A Disabled Child who terminates his/her coverage under the Plan will not be able to re-enroll unless the Disabled Child qualifies as a Special Enrollee and provides the required documentation to the Plan.
 - **Requirements for Initial or Special Enrollment of Disabled Child.** A Disabled Child may be enrolled in the Plan after attaining age 26, due to an initial or special enrollment, provided that within thirty-

one (31) days of the date of hire of the Employee or within the 31-day special enrollment period, the following are furnished to and approved by the Plan:

- Satisfactory written proof that such incapacity and dependency existed as of the date the Disabled Child attained age 26; and
- Satisfactory written proof that the Disabled Child was covered under a major medical insurance plan (such as coverage through the Marketplace, an individual health insurance plan, or other group health plan coverage) immediately prior to the date of hire of the Employee or special enrollment period and did not experience a break in coverage of more than sixty (60) days.

The Disabled Child will remain a Covered Dependent provided that the child continues to qualify as a Disabled Child and a Dependent. The Plan may require, at reasonable intervals, subsequent proof of incapacity and dependency satisfactory to the Plan.

- **Dependent Limitations.** In addition to the above limitations, Dependent does not include:
 - The spouse if on active duty in the Armed Forces of any country, unless such spouse is considered a TRICARE eligible employee, as defined under 10 U.S.C. § 1086;
 - A grandchild of the Participant or the Participant's Spouse, unless either is named the legal guardian of the child.

For purposes of coverage under this Plan, if both parents are Participants, a Dependent shall only be covered as a Dependent under this Plan by one parent.

Disability shall mean any congenital or acquired physical or mental illness, defect or characteristic preventing or restricting an individual from participating in normal life, or limiting the individual's capacity to work. Such Disability must be certified by a Doctor.

Doctor shall mean a properly licensed person holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), or Doctor of Dental Surgery (D.D.S.).

Durable Medical Equipment shall mean equipment prescribed by a Doctor, which meets all of the following requirements:

- Is Medically Necessary;
- Is primarily and customarily used to serve a medical purpose;
- Is designed for prolonged and repeated use;
- Is for a specific therapeutic purpose in the treatment of an illness or injury;
- Would have been covered if provided in a Hospital; and
- Is appropriate for use in the home.

Effective Date shall mean the first day of coverage under this Plan as set forth in the Enrollment and Contributions for Participants and Dependents Section.

Eligible Retiree shall mean each Employee who is a Participant in the Plan during the 3 month period immediately prior to retirement from a Member, was Actively at Work on the day prior to retirement, meets both a minimum age of 55 years and a minimum service of 10 years of continuous service as an Employee with a Member, and the sum of such Employee's age and years of service is at least 70.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would place the individual's health in serious jeopardy, or seriously impair bodily functions, bodily organs, or parts.

Emergency Services or Emergency means, with respect to an Emergency Medical Condition:

- A medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the Emergency department of a hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition, and
- Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under section 1867 of such Act to Stabilize the patient.

Employee shall mean:

- An Employee regularly scheduled to work at a position for a minimum of 75% of a full time Employee load as defined by the Member **and** shall not be less than 30 hours per week or 1560 hours per year;
- A faculty member teaching a minimum 75% of a full time teaching load, or equivalent, during the academic year with a Member;

(For purposes of this calculation, Adjunct Faculty will be calculated with (a) 2.25 hours of service per week for each hour of teaching or classroom time, which represents a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers, and, separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform, such as required office hours or required attendance at faculty meetings. The Member colleges may also use an alternate reasonable method that can be considered consistent with the above method, to calculate an Adjunct Faculty's hours of service.)

- An Employee that participates in either a "phased retirement" or "flexible retirement" program as defined by the employing Member institution;
- An Employee on an Approved Leave of Absence;
- An Employee on an Approved Sabbatical; or
- An Employee on an Approved Disability Leave.

The term **Employee** shall not include

- Leased Employees;
- Collectively bargained Employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals;
- Temporary Employees;
- A member of the Member's board of directors, an owner, partner or officer unless engaged in the conduct of the business on a full time basis;
- An independent contractor or consultant who is paid on other than a regular wage or salary by the Member; or
- A student Employee that is not paid or who is not entitled to pay or who is engaged in a federal work study program or similar program of a state or a political subdivision of a state.

Employer shall have the same meaning as Member, below.

ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

Experimental/Investigative is any service or supply that is judged to be experimental or investigative at the HMO's sole discretion. Refer to **Exhibit A** for more information.

Extended Care Facility shall mean an institution which:

- Is duly licensed as an Extended Care Facility, convalescent facility, or Skilled Nursing Facility and operates in accordance with governing laws and regulations;
- Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;
- Is staffed with a Doctor or Registered Nurse on duty 24 hours a day;
- Operates in accordance with medical policies, whereby such policies are supervised and established by a Doctor other than the patient's own Doctor;
- Regularly maintains a daily medical record for each patient;
- Is not, other than incidentally, a place for the aged, a place for individuals addicted to drugs or alcohol, or a place for Custodial Care; and
- Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

Family shall mean a Participant and covered Dependents.

Generic Drugs are simply copies of brand-name drugs. Brand-name and generic drugs have the same active ingredients, strength and dose. And the FDA requires that generic drugs meet the same high standards for purity, quality, safety and strength.

High Dose is a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

HMO Physician is a duly licensed Doctor of medicine or osteopathy who has contracted with the HMO to provide medical services to Covered Persons.

HMO Provider is a medical group, HMO Physician, Hospital, Skilled Nursing Facility, or any other duly licensed institution or health professional who has contracted with the HMO or its designee to provide Covered Services to Covered Persons. A list of HMO Providers is made available to each Participant prior to enrollment. A current list may be obtained from the HMO upon request and may be seen by visiting the HMO's website page at www.anthem.com. The list shall be revised by the HMO from time to time as the HMO deems necessary.

HMO, We, Us, Our refers to HealthKeepers, Inc.

Home Health Care Agency shall mean any of the following:

- A Home Health Care Agency licensed by the jurisdiction in which it is located;
- A Home Health Agency as defined by the Social Security Administration; or
- An organization licensed in the jurisdiction in which it is located which is an appropriate provider of Home Health Services, and which meets the following requirements:
 - Has a full time administrator;
 - Keeps written medical records; and
 - Has at least one Registered Nurse (R.N.) on staff, or the services of an R.N. available.

Home Health Care Services shall mean the following care provided to the Covered Person at the Covered Person's home or a Home Health Care Agency on recommendation of a Doctor:

- Intermittent care by a:
 - Registered Nurse (R.N.);
 - Licensed Practical Nurse (L.P.N.);
 - Home Health Aide;
 - Occupational and Physical Therapist;
 - Licensed Vocational Nurse (L.V.N.);
 - Physical Therapist Assistant (P.T.A.); or
 - Certified Occupational Therapist Assistant (C.O.T.A.).
- Private duty nursing services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
- Social work; and
- Nutrition services, including special meals.

Hospice shall mean a public agency or a private organization which provides care and services for Terminally Ill persons and their families. Such agency or organization must be qualified to receive Medicare payments, or satisfy the following requirements:

- Provides and has available 24 hours per day:
 - Palliative and supportive care for Terminally Ill persons;
 - Services which encompass the physical, psychological and spiritual needs of Terminally Ill persons and their Families; and
 - Acute Inpatient Care, Outpatient Care, and Home Health Care. Care and counseling must be furnished directly by, or under the arrangement of such agency or organization;
- Has a medical director who is a Doctor;
- Has an interdisciplinary team to coordinate care and services, which includes at least one Doctor, one R.N. and one social worker; and
- Is licensed or accredited as a Hospice, if the laws of the jurisdiction in which it is located allow for the licensing or accreditation of Hospices.

Hospice Care shall mean care rendered by a Hospice in response to the special physical, psychological and spiritual needs of Terminally Ill Covered Persons and/or their Family members.

Hospital shall mean an institution which makes charges and is engaged primarily in providing Medical Care to sick and injured persons on an Inpatient basis at the patient's expense which fully meets all the requirements set forth below:

- Operates in accordance with the law of the jurisdiction in which it is located pertaining to institutions identified as Hospitals; as well as, primarily engages in providing Medical Care of injured and sick persons by or under the supervision of a staff of Doctors or surgeons for compensation from its patients on an Inpatient basis. It continuously provides 24 hour nursing services by Registered Nurses; maintains facilities on the premises for major operative surgery. A Hospital is not, (other than incidentally) a nursing home,

a place for rest, a place for the aged, a place for the mentally ill or emotionally disturbed, or a place for the treatment of Substance Use Disorders.

- Accredited by the Joint Commission of Accreditation of Hospitals (“JCAH”) or is recognized by the American Hospital Association (“AHA”) and is qualified to receive payments under the Medicare program.
- A psychiatric Hospital, as defined by Medicare, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare.

Illness shall include disease, mental, emotional, or nervous disorders, and pregnancy.

In-Network shall mean the services or supplies provided by a Participating Provider, or authorized by any of the VPC Benefits Consortium’s contracted managed care Networks.

Incurred Charges shall mean charges for services or supplies that are actually received. A charge shall be considered an Incurred Charge on the date the supplies or services are actually received.

Injury shall mean bodily Injury, including pregnancy following an act of rape or incest.

Inpatient refers to a person receiving care while you are a bed patient in a Hospital or Skilled Nursing Facility.

Inpatient Care shall mean Medical Care provided to an Inpatient.

Maintenance Prescription Drugs are those you take on a regular, recurring basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes.

Maximum Allowed Amount is the allowance as determined by the HMO for a specified Covered Service or the provider’s charge for that service, whichever is less.

Medical Care shall mean professional services rendered by a Doctor or Other Professional Provider for the treatment of an Illness or Injury.

Medically Necessary to be considered Medically Necessary, a service must:

- Be required to identify or treat an Illness, injury, or pregnancy-related condition;
- Be consistent with the symptoms or diagnosis and treatment of your condition;
- Be in accordance with standards of generally accepted medical practice; and
- Be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient’s Family, or the provider.

Medicare shall mean Title XVIII of the United States Social Security Act, as amended, and the Regulations promulgated thereunder.

Member shall mean the independently governed and operated institutions of higher education in the Commonwealth of Virginia who are Members of the Council of Independent Colleges in Virginia, operating as Virginia Private Colleges, and who are approved for membership as set forth in the Articles of Incorporation and Bylaws of the VPC Benefits Consortium. The term Member shall also mean any affiliated foundation or other entity associated with such institutions, and any other entity adopting the Plan with the approval of its governing body and the VPC Benefits Consortium as set forth in its Articles of Association. If a Member merges or is otherwise consolidated with any affiliate, the successor shall, as to the group of Members covered by the Plan immediately before such merger or consolidation, be the Member as defined hereunder, unless the VPC Benefits Consortium specifies to the contrary. In the case of any other merger or consolidation, the successor shall not be the Member except to the extent that it acts, with the approval of the VPC Benefits Consortium, to adopt the Plan.

Member Services shall mean Anthem Blue Cross and Blue Shield (“Anthem HealthKeepers” or “HealthKeepers”) and is the Claims Administrator under the Plan.

Mental Health and Substance Use Disorder Services are for the diagnosis and treatment of a psychiatric condition, including nervous, mental, and emotional disorders, and alcohol and drug abuse.

Morbid Obesity shall mean a body mass index (BMI) of 40.0 or greater, where BMI equals weight in kilograms divided by height in meters squared.

Network shall mean any preferred provider or managed care Network under contract with the VPC Benefits Consortium to provide or arrange to provide services or supplies to Covered Persons.

Other Facility Provider shall mean any of the following: Ambulatory Care Facility, Substance Use Disorder Treatment Facility, free-standing dialysis facility, Outpatient psychiatric facility, psychiatric Day Treatment facility, psychiatric Hospital, Hospice, Extended Care Facility, or rehabilitation facility, which is licensed as such in the jurisdiction in which it is located.

Out-of-Network shall mean Drugs, devices, procedures, services, treatments or supplies which are not provided by a Participating Provider or approved by any of VPC Benefits Consortium’s contracted managed care Networks.

Out-of-Plan shall mean services provided by any Hospital, Doctor, pharmacy, Other Professional Provider, Other Facility Provider or other entity that is not under contract with the VPC Benefits Consortium’s contracted managed care Networks.

Out-of-Plan Benefits are benefits for services received from a non-HMO Provider.

Out-of-Pocket (or Out-of-Pocket Amounts/Costs/Expenses) shall mean any amount of Deductible and Coinsurance that the Covered Person or Family pays for a Covered Expense during the Calendar Year as specified in the associated SBCs.

Out-of-Pocket Maximum shall mean the maximum amount of Deductible and Coinsurance during any Calendar Year that the Covered Person or Family shall pay before the Plan shall pay 100% of Covered Services for that Calendar Year. Hospital Admission Copayments or Coinsurance apply to the Out-of-Pocket Maximum. *Refer to “out-of-pocket limit” in the associated SBC.

Outpatient refers to a person receiving care in a Hospital Outpatient department, Emergency room, Professional Provider’s office, or your home.

Outpatient Care shall mean Medical Care provided to a Covered Person while the Covered Person is an Outpatient.

Outpatient Mental Health Services are for the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

Outpatient Surgery shall mean surgical services provided to the Covered Person while the Covered Person is an Outpatient.

Part Time Employee shall mean:

- An Employee regularly scheduled to work at a position for a minimum of 1000 hours per year or equivalent, but less than the required number of hours to meet the definition of an Employee; or
- A faculty member teaching at least 50% of a full teaching load, or equivalent, but less than the required teaching load to meet the definition of an Employee, as determined by the Member Institution.

(For purposes of this calculation, Adjunct Faculty will be calculated with (a) 2.25 hours of service per week for each hour of teaching or classroom time, which represents a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers,

and, separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform, such as required office hours or required attendance at faculty meetings. The Member colleges may also use an alternate reasonable method that can be considered consistent with the above method, to calculate an Adjunct Faculty's hours of service.)

The term Part Time Employee shall not include:

- Leased Employees;
- Collectively bargained Employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals;
- Temporary Employees;
- A Member of the Member's board of directors, an owner, partner or officer unless engaged in the conduct of the business on a full time basis;
- An independent contractor or consultant who is paid on other than a regular wage or salary by the Member; or
- A student Employee that is not paid or who is not entitled to pay or who is engaged in a federal work study program or similar program of a state or a political subdivision of a state.

A Part Time Employee must properly enroll in the Plan, continuously meet the requirements for eligibility and pay the required contributions on a timely basis, as described in the Enrollment Contributions Section.

Partial Day Services include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or Substance Use Disorder, or an intensive Outpatient program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence. Partial Day Services are used as an alternative to Inpatient treatment.

Participant shall mean an Employee, Part Time Employee, or Eligible Retiree who meets the requirements for eligibility and properly enrolls in the Plan and continuously meets the requirements for eligibility.

Participating Doctor shall mean a duly licensed Doctor under contract with any of the VPC Benefits Consortium's contracted managed care Networks.

Participating Provider shall mean any Hospital, Doctor, pharmacy, Other Professional Provider, Other Facility Provider or other entity under contract with the VPC Benefits Consortium's contracted managed care Networks. The participation status may change from time to time. Refer to the provider directory or contact Member Services for a listing of the Participating Providers.

Physician shall have the same meaning as Doctor, above.

Plan, The Plan or This Plan shall mean Virginia Private Colleges Benefits Consortium, Inc. Health Plan.

Plan Administrator shall mean Tim Klopfenstein, Executive Director of the VPC Benefits Consortium.

Plan Year shall mean January 1st through December 31st of each year.

Post-Service Claims shall mean all claims other than Pre-Service, Urgent Care or Concurrent Care Claims. Post-Service Claims include claims filed after services are rendered and claims that do not require Preauthorization of the service, even where the Covered Person requests Preauthorization.

Pre-Service Claims shall mean claims for a service where the terms of the Plan Document require the Covered Person to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to

receive authorization for a service when Preauthorization is not required, that claim will be considered a Post-Service Claim.

Preauthorization or Preauthorized shall mean the preapproval of a Covered Expense for all services specified by the Plan as requiring preapproval.

Prescription Drugs are medicines, including insulin and growth hormones that require a prescription order from your Doctor.

Preventive Care shall have the meaning set forth in Section 7.

Primary Care Physician (“PCP”) is the HMO Physician you may select to provide your primary health care services. PCPs specialize in the areas of general practice, Family practice, internal medicine, and pediatrics.

Professional Provider or (Other Professional Provider) shall mean the following persons or practitioners, including Doctors, acting within the scope of such provider’s license, which is certified and licensed in the jurisdiction in which the services are provided:

- Audiologist;
- Anesthesiologist;
- Certified Nurse Practitioner;
- Clinical Social Worker;
- Dentist;
- Emergency medical technician;
- Independent laboratory technician;
- Licensed Practical Nurse;
- Nurse Midwife;
- Occupational Nurse;
- Occupational Therapist;
- Pharmacist;
- Physical Therapist;
- Doctor Assistants;
- Registered Nurse;
- Respiratory Therapist; and/or
- Speech - Language Pathologist or Audiologist.

Qualified Beneficiary is the Participant or a covered Dependent who is eligible to continue coverage under COBRA.

Reconstructive Surgery Following Mastectomy shall mean surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes all stages of reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive breast surgery shall also include augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

Service Area is the geographic area within which Covered Services are available.

Skilled Nursing Care shall mean service provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), provided the care is Medically Necessary and the treating Doctor has prescribed such care.

Skilled Nursing Facility shall mean an institution which:

- Is duly licensed as an Extended Care Facility or convalescent facility, and operates in accordance with governing laws and regulations;
- Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;
- Is staffed with a Doctor or Registered Nurse on duty 24 hours a day;
- Operates in accordance with medical policies supervised and established by a Doctor other than the patient's own Doctor;
- Regularly maintains a daily medical record for each patient;
- Is not, other than incidentally, a place for the aged, a Substance Use Disorder Treatment Facility, or a place for Custodial Care; and
- Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

Special Enrollee shall mean an Employee or Dependent who is entitled to and who requests Special Enrollment as described in the Enrollment and Contributions Section.

Specialist shall mean Doctors who generally specializes in one field of medicine (i.e. Cardiologist, Neurologist).

Spinal Manipulation Treatment shall mean office visits or treatment, which involve manipulation (with or without the application of treatment such as heat, water or cold therapy, diathermy or ultrasound) of the spinal skeletal system and surrounding tissues to allow free movement of joints, alignment of bones, or enhancement of nerve functions.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver (including the placenta).

Substance Use Disorder shall mean an addiction to either drugs and/or alcohol.

Substance Use Disorder Treatment Facility shall mean a facility, other than an acute care Hospital, established to care and treat those who need Inpatient Medical Care due to alcoholism or drug abuse. The institution must have permanent facilities on the premises for Inpatient Medical Care. The institution must be licensed, registered or approved by the appropriate authority of the jurisdiction in which it is located or it must be accredited by the American Hospital Association. It must keep daily medical records on all patients. A Substance Use Disorder Treatment Facility shall not include an institution, or part of one, used mainly for rest care, nursing care, care of the aged or Custodial Care.

Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Telemedicine Services do not include an audio-only telephone conversations, electronic mail message, or facsimile transmission.

Terminal Illness or Terminally Ill shall mean a life expectancy of 6 months or less.

Termination of Employment or Terminates Employment shall mean the severance of an Employee's employment relationship with a Member and all other affiliates, or the expiration of an Approved Leave of Absence, Approved

Sabbatical or leave mandated by the Family and Medical Leave Act from a Member without the Employee returning to the employment of such Member or any affiliate.

Tier 1 Drugs (formerly “Generics”) have the lowest cost share. These (usually generic) drugs offer the best value compared to other drugs that treat the same conditions.

Tier 2 Drugs (formerly “Preferred Brands”) have a higher cost share than Tier 1 drugs. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some may be generic drugs that may cost more because they are newer to the market.

Tier 3 Drugs (“formerly “Non-Preferred Brands”) have a higher cost share than Tier 2 drugs. They often include non-preferred brand and generic drugs. They may cost more than drugs on lower tiers used to treat the same condition. Tier 3 may also include drugs recently approved by the FDA.

Tier 4 Drugs (formerly “Specialty”) have a higher cost share than Tier 3 drugs and usually include preferred specialty brand and generic drugs. They may cost more than drugs on lower tiers used to treat the same condition. Tier 4 may also include drugs recently approved by the FDA or specialty drugs used to treat serious, long-term health conditions and that may need special handling.

Urgent Care Claims shall mean claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient’s life, health or ability to regain maximum function, or in the opinion of the patient’s Physician, would subject the patient to severe pain. The Plan will defer to the patient’s Physician as to whether a claim involves urgent care. Notwithstanding any provision of this Plan Document, services for an Emergency do not require any type of HMO Preauthorization.

Urgent Care Situations are medical conditions that require immediate attention, but are not as severe as an Emergency. Urgent Care Situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an Illness or Injury.

Waiting Period shall mean the period that must pass under this Plan before an Employee or Dependent is eligible to enroll in the Plan (or other health plan as the case may be). Notwithstanding the foregoing, if an Employee or Dependent enrolls as a Special Enrollee on a Special Enrollment Date, any period before such Special Enrollment is not a Waiting Period.

You, Your means any Covered Person.

Experimental/Investigative Criteria

Experimental/Investigative means any service or supply that is judged to be experimental or investigative at the HMO's sole discretion. Nothing in this exclusion shall prevent a Covered Person from appealing the HMO's decision that a service is Experimental/Investigative. Services which do not meet each of the following criteria will be excluded from coverage as Experimental/Investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.
 - (a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
 - The following three standard reference compendia defined below:
 - (1) American Hospital Formulary Service – Drug Information
 - (2) National Comprehensive Cancer Network's Drugs & Biologics Compendium
 - (3) Elsevier Gold Standard's Clinical Pharmacology
 - In substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a specific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or
 - (b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.
3. The available scientific evidence must show a good effect on health outcomes outside a research setting.
4. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered Experimental/Investigative.

Clinical Trials

Benefits:

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - (a) The National Institutes of Health.
 - (b) The Centers for Disease Control and Prevention.
 - (c) The Agency for Health Care Research and Quality.
 - (d) The Centers for Medicare & Medicaid Services.
 - (e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - (g) Any of the following Departments listed in this subpart (g) below if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines: 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - The Department of Veterans Affairs.
 - The Department of Defense.
 - The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

You may be required to use an In-Network provider to maximize your benefits. You must call Member Services to find out.

When a requested service is part of an approved clinical trial, it is a covered service even though it might otherwise be investigational as defined by this plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our clinical coverage guidelines, related policies and procedures.

Exclusions:

The plan may not provide the benefits listed immediately below and reserves the right to exclude any of the following:

1. The investigational item, device, or service, itself; or
2. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Special Features and Programs

We may offer health or fitness related program options to the group to purchase. If your group has selected this option, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. (Use of gift cards for purposes other than for qualified medical expenses may result in taxable income to you. For additional guidance, please consult your tax advisor.) These programs are not Covered Services under the plan but are in addition to plan benefits; these program features are not guaranteed under your certificate and could be discontinued at any time.

In addition to the health and wellness benefits under your health plan, or any health or fitness related program options that may be offered to your group to purchase, our 360° Health® program surrounds you and your Family members with 360 degrees of Preventive Care resources, wellness information, savings and incentives and care management services.

Our 360° Health program focuses on helping you manage your health and make the right health care decisions for you and your Family. When you have medical conditions, you can turn to the programs that make up 360° Health. The program components are each designed to help you get the right care at the right time and help you lead the healthiest life possible. All the parts of 360° Health are located in one consumer-friendly source on anthem.com that you can tap into whether you're healthy and just want to stay that way or living with a chronic condition that needs regular attention.

Although these services are not part of the health and wellness benefits under your health plan, they are provided to you as a plan participant. Discount services are available through networks administered by other companies – many of which are national leaders in their fields. The discount services listed below are not covered as benefits under your health plan and can be discontinued at any time.

Health resources and tools

MyHealth@Anthem®

When you visit anthem.com, you can access this personalized online resource center. It's full of interactive tools to help you assess, manage and improve your health. You can take advantage of:

- Health risk assessments – Learn your overall health status by completing a health risk assessment.
- LEAP Fitness Program – Use the Lifetime Exercise Adherence Program (LEAP) to create online fitness programs and personalized activity plans.
- Condition Centers – When you visit a Condition Center, you can access in-depth, condition-specific health assessments and personalized treatment options. Condition Centers exist for allergy, anxiety, diabetes, prostate health, breast health and more.
- Physician Pre-Visit Questionnaire – Use this to get ready for your next Doctor's visit. It can help you ask the right questions and communicate effectively with your Doctor.
- Child Health Manager and Pregnancy Planner – Track your children's Doctor visits, immunization records and any medical concerns you have. Expectant mothers can track their pregnancy check-ups, tests, progress and more.
- Message Center and Health News – Receive health-related secure e-mails with current news, drug alerts and health tips based on your personal health interests and profiles.

- Depression and Anxiety Screening – Answer general questions about depression and anxiety. Based on your responses, a nurse care manager may follow up with you to discuss treatment options and offer support.

AudioHealth Library

For those who aren't comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, there's the AudioHealth Library. It's accessible by phone with more than 400 recorded health topics.

Online Preventive Guidelines

At anthem.com, you can use the online preventive guidelines to check on when you should have certain check-ups, immunizations, screenings and tests.

Healthy Solutions Newsletter

Mailed to your home twice a year, this wellness and benefits newsletter can help you make wiser decisions about your health and the care you need. Packed with practical information, it can help you get the most value out of your health care benefits.

SpecialOffers@AnthemSM

With SpecialOffers@Anthem, you can access discounts on a wide variety of health and wellness products and services. Find deals on natural health and wellness products; acupuncture, chiropractic and massage therapy; fitness club memberships; weight management; laser vision correction and recommended health and wellness books.

The discount programs and services available through SpecialOfficers@Anthem are continually reviewed for opportunities to provide more value to your membership. For the most up-to-date information, always refer to SpecialOffers@Anthem at anthem.com. These discount programs and services are independent of your plan benefits and may change or be cancelled at any time.

Health Guidance

Staying Healthy Reminders

Postcards and phone calls remind you and your Family when it's time for certain Preventive Care or screenings like immunizations, mammograms and colorectal cancer screening tests. Covered Persons identified with hypertension are sent reminders for certain tests and medication refills.

24/7 NurseLine

Illness or Injury can happen, no matter what time of day. As an HMO Covered Person you have access to a team of nurses, available to assist with your questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms you're experiencing, how to get the right care in the right setting and more, and you can call as often as you like. Call 800-337-4770.

Future Moms

This program promotes health pregnancies and is designed for all expectant women – whether they're experiencing routine pregnancies or at highest risk for complications. When Covered Persons enroll in the Future Moms program, they receive an up-to-date prenatal care package with valuable information for the whole Family. A team of nurses – specializing in obstetrics and experienced in working with expectant mothers – is available 24/7 to help Covered Persons try and have the healthiest pregnancies possible.

Health management and coordination

ComplexCare

This program helps Covered Persons living with multiple health care issues. Our goal is to help you access quality care, learn to effectively manage your condition and lead the healthiest life possible. When you enroll in the program, you're assigned to a nurse care manager who specialized in helping high-risk people.

The nurse care manager will work with you and your Doctor to create an individualized care plan, coordinate care between different Doctors and health care providers, develop personalized goals, offer health and lifestyle coaching, answer your questions and more.

ConditionCare

If you or a Family member suffers from a chronic condition like asthma, we may be able to help you achieve better health. Our ConditionCare program gives you personalized support to take charge of your health and maybe even improve it.

We'll help you manage your symptoms related to pediatric and adult asthma, chronic obstructive pulmonary disease, pediatric and adult diabetes (Types I and II), heart failure, coronary artery disease and kidney disease. The ConditionCare program gives you:

- 24-hour toll free access to registered nurses who can answer your questions, provide support and educate you on how to best manage your condition.
- A health evaluation and consultation with a registered nurse over the phone, when needed, to help you manage your condition.
- Educational materials like care diaries, self-monitoring charts and self-care tips.

To enroll in the ConditionCare program, call us toll-free at 800-445-7922.

Vision Program

To help you care for your eyes, valuable vision discounts are available to you in addition to the routine vision benefits defined in the **What is covered** section of this Plan Document. In order to take advantage of the available discounts, you should seek care from a Blue View Vision Participating Provider.

Your Eyewear Discounts

When you visit a Blue View Vision participating eye care professional or vision center, you will pay the discount price for as many pairs of eyeglasses and/or supplies of conventional (non-disposable) contact lenses as you would like.

Your eyewear discounts/costs at participating Blue View Vision provider offices are as follows:

Service	Covered Person Cost
Frame	35% off retail price
Standard Plastic Lenses	
Single Vision	\$50
Bifocal	\$70
Trifocal	\$105
Lens Options	
UV Coating	\$15
Tint (Solid and Gradient)	\$15
Standard Scratch-Resistance	\$15
Standard Polycarbonate	\$40
Standard Progressive (Add-on to bifocal)	\$65
Standard Anti-Reflective Coating	\$45
Other Add-ons and Services	20% off retail price
Contact Lenses	
Conventional (non-disposable) – materials only	15% off retail

*Discounts apply towards a complete pair of eyeglasses. If eyeglass materials are purchased separately, a 20% discount is applied.

Plus, Anthem Covered Persons have access to discounts on laser vision correction surgery and other vision discounts through SpecialOffers@Anthem.

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Appendix A
Summaries of Benefits and Coverage for Plans 8-11

Below is a comprehensive list of Summaries and Benefits and Coverage associated with this Plan Document and Summary Plan Description. See the Summary of Benefits and Coverage for Your Member college for additional Plan information.

- Plan 8 HMO POS & HSA (Embedded Deductible) Summary of Benefits and Coverage
- Plan 9 HMO POS Open Access Summary of Benefits and Coverage
- Plan 10 HMO POS Open Access Summary of Benefits and Coverage
- Plan 11 HMO POS Open Access Summary of Benefits and Coverage

If you have any questions about which plans are available to you at your Member college, please contact your Human Resources Department.

Appendix B
Summaries of Benefits for Plans 8-11

Below is a comprehensive list of Summaries and Benefits associated with this Plan Document and Summary Plan Description. See the Summary of Benefits for Your Member college for additional Plan information.

- Plan 8 HMO POS & HSA (Embedded Deductible) Summary of Benefits
- Plan 9 HMO POS Open Access Summary of Benefits
- Plan 10 HMO POS Open Access Summary of Benefits
- Plan 11 HMO POS Open Access Summary of Benefits

If you have any questions about which plans are available to you at your Member college, please contact your Human Resources Department.

Appendix C
Temporary Amendments for COVID-19

Unless otherwise specified, terms capitalized in this Appendix B shall have the same meaning as the defined terms in the Plan Document to which this Appendix is attached.

This Appendix B, as may be referenced in the Plan Document, specifies certain temporary amendments to be made to the Plan due to the COVID-19 public health emergency and pursuant to certain guidance provided by Congress and the federal agencies. This Appendix may be amended or removed at any time to remain in compliance with current guidance.

The following temporary amendments are being made to the Plan as a result of the COVID-19:

- **COVID-19 Test Kits.** Coverage of Food & Drug Administration (“FDA”) approved, over the counter COVID-19 testing kits. Participants have two options for purchasing COVID-19 test kits:
 - o Participants may order test kits online at www.Anthem.com or on the Sydney mobile application.
 - Coverage of such test kits shall be at no cost to the Participant.
 - Coverage of such test kits shall not include shipping expenses.
 - o Participants may purchase test kits directly from a drug store or online vendor and be reimbursed for the full cost of the test kit.
 - Coverage of such test kits shall include sales tax.
 - Coverage of such test kits shall not include shipping expenses.
 - Participants may purchase up to eight (8) test kits per month.
 - In order to be reimbursed for purchasing such test kits, Participants must file a claim online at www.Anthem.com, or on the Sydney mobile application, and upload a picture of the receipt or submit a paper receipt by mail.

For either option, Participants must certify that the purchase of such test kits is for personal use and not for employment purposes.

Participants should not collect or hoard over the counter COVID-19 testing kits as the kits do expire.