Benchmark Equivalent Coverage Analysis

Healthy Indiana Plan Demonstration

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BACKGROUND

This report was developed in response to a request from the Center for Medicare and Medicaid Services (CMS). In a February 15, 2013 letter, Diane Heffron requested a benefit analysis of the Healthy Indiana Plan (HIP) section 1115 demonstration.

CMS will use this benefit analysis to determine whether coverage provided under HIP as of December 1, 2009 represented “full benefits”, “benchmark”, or “benchmark-equivalent” coverage.

The performance of this benefit analysis will not obligate Indiana to expand Medicaid.

Details of CMS’ request are included in Attachment A to this report. The report is structured in the same manner as the request.

SECTION 1 – BENEFIT ASSESSMENT TO SUBSTANTIATE NEWLY ELIGIBLE

The newly eligible FMAP is only available to states that, as of December 1, 2009, did not provide "full state plan benefits", "benchmark", or "benchmark-equivalent" coverage to low-income adults in the new adult coverage group, either through the Medicaid state plan or through a section 1115 demonstration.

As of December 1, 2009, the state provided coverage to uninsured custodial parents and caretaker relative adults (ages 19 through 64) with income above the AFDC income limit up to and including 200 percent of the federal poverty level (FPL) and uninsured non-custodial parents and childless adults (ages 19 through 64) with family income up to and including 200 percent of the federal poverty level (FPL).

Coverage was provided through the Healthy Indiana Plan (HIP) demonstration (Project Number 11-W-00237/5).

1. ENROLLMENT LIMIT

As of December 1, 2009, the demonstration Special Terms and Conditions restricted enrollment for non-custodial parents and childless adults to 34,000. There was no specific enrollment cap for custodial parents and caretaker relatives; although, the state was allowed to modify eligibility if funding was not available.

2. FULL BENEFITS

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not include all benefits available under the state's approved Medicaid plan. For example, HIP did not cover maternity benefits, vision benefits, dental benefits, Medicaid rehabilitation option services, chiropractic benefits, hearing aids, non-emergency transportation benefits, and others. In addition, benefit limitations often differed from those in the state plan.

HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. In addition, enrollees were required to make monthly contributions to a POWER account. Those who did not make required contribution were dis-enrolled.

3. BENCHMARK COVERAGE

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not represent "benchmark coverage", as described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act.

The demonstration did not include the entire range of services offered under the three benchmark commercial packages, as in effect December 1, 2009.

The Standard BCBS PPO, as offered under the FEHBP

The demonstration did not include the entire range of service offered under the Federal Employees Health Benefit Program (FEHBP), as in effect December 1, 2009. The demonstration did not include maternity services, chiropractic services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. Although the FEBHP plan contains lifetime maximum benefits for specific services (for example wigs or substance abuse treatment), there is no overall lifetime maximum benefit limit.

The State Employee PPO

The demonstration did not include the entire range of service offered under the State employee PPO, as in effect December 1, 2009. The demonstration did not include maternity services, chiropractic services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. The State Employee PPO has no annual limit, but has a lifetime benefit limit of $2,000,000 per member.

The HMO with the largest insured non-Medicaid enrollment

The demonstration did not include the entire range of service offered under the Advantage HMO, as in effect December 1, 2009. The demonstration did not include maternity services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. The Advantage HMO does not have an overall lifetime maximum benefit limit.

4. BENCHMARK EQUIVALENT COVERAGE

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not represent "benchmark coverage", as described in section 1937(b)(2) of the Act.

Inclusion of Basic Services

i. Inpatient and outpatient hospital
   The demonstration package covered most inpatient and outpatient hospital services. However, Maternity services were not covered under HIP.
ii. Physicians' surgical and medical services
   The demonstration package covered physician services.
iii. Lab and x-ray services
   The demonstration package covered lab and x-ray services.
iv. Emergency services, as required in 42 CFR 440.335(b)(5)
   The demonstration package covered emergency services, as required in 42 CFR 440.335(b)(5).

42 CFR 440.335(b)(5) requires benchmark benefit packages to include coverage of essential health benefits. Please note that « Maternity and newborn care » is listed as an essential health benefit under Section 1302(b)(1)(D) of the Patient Protection and Affordable Care Act.

HIP also provides only limited coverage of another essential benefit: "Rehabilitative and Habilitative services and devices" (ACA Section 1302(b)(1)(G)). For example, HIP does not cover hearing aids, safety glasses, athletic glasses, treatment for learning disabilities, or foot care.

Aggregate Actuarial Value

The study developed an aggregate actuarial value for the Healthy Indiana Plan demonstration and each of the three benchmarks. The actuarial values are illustrated in Table 1 below.

Table 1 Actuarial Value – Aggregate Plan Healthy Indiana Plan Demonstration compared with benchmarks	
Plan	**Actuarial Value**
Standard BCBS PPO	83%
State employee plan	86%
Largest HMO	83%
HIP Demonstration	75%

The aggregate actuarial value of the demonstration is lower than all three benchmarks. The difference is larger than the +/- 2% *de minimis* standard to be used on Affordable Insurance Exchanges.

Prescription Drugs, Mental Health, Vision, or Hearing services

The actuarial value of prescription drug, mental health, vision, and hearing benefits provided by the Healthy Indiana Plan demonstration was compared to each of the three benchmarks. The actuarial values are illustrated in Table 2 below.

Table 2 Actuarial Value for Specific Services Healthy Indiana Plan Demonstration compared with benchmarks				
Plan	**Drug**	**Mental health**	**Vision**	**Hearing**
Standard BCBS PPO	82%	73%	82%	89%
State employee plan	93%	83%	82%	78%
Largest HMO	82%	54%	82%	100%
HIP Demonstration	100%	100%	0%	100%

The actuarial value calculated for each service is illustrated net of service-specific cost sharing such as copays and coinsurance, but before application of global cost sharing such as deductibles and out of pocket maximums.

The benchmark plans all include at least a basic level of vision services that allows for coverage of eyeglasses when related to an injury or specific medical condition. The demonstration does not cover vision services under any circumstances. Under section 1937(b)(2)(C) of the Act, vision service coverage for benchmark equivalent plans is required to have an actuarial value that is at least 75% of the benchmark.

The benchmark plans all make subsidized optional dental and vision plans available to members, but these optional plans have not been included in our analysis.

Actuarial Value Calculation

Milliman has provided a certificate of actuarial value of the demonstration benefit package as part of this report. The analysis conforms to the following guidelines:

i. The study was performed in accordance with generally accepted actuarial principles and methodologies. All Actuarial Standards of Practice promulgated by the Actuarial Standards Board have been observed.
ii. The study uses a standardized set of utilization and price factors for the demonstration plan and the benchmarks. The utilization is representative of an adult population and Medicare pricing was used.
iii. The study uses a standardized population for evaluating the demonstration plan and the benchmarks. In order to be representative of the potential new adult coverage group, an adult non-Medicare population was used, with an age and gender distribution similar to that of the population that would be eligible for the new adult coverage group in Indiana. Coverage is assumed to be self-only (no family or dependent coverage).
iv. The demonstration was compared to the benchmarks using the same principles and factors in comparing the value of different coverage. The same actuarial cost model was used for all plans, modified only to reflect different plan provisions, such as benefits covered and cost sharing provisions.
v. The analysis does not take into account any differences in coverage based on method of delivery or means of cost control or utilization used.
vi. The analysis reflects cost sharing requirements for each plan.

Appendix B contains actuarial cost model summaries for the HIP demonstration and each benchmark plan.

Data

CMS suggested actual claims experience from the demonstration population be used as a data source for the average utilization and cost information needed to determine actuarial value. Milliman's preliminary analysis explored this option, and identified two issues with this approach:

- The enrolled demonstration population is not representative of those who would be eligible for the new adult coverage group under a Medicaid expansion. The demonstration population is significantly older, more female, and less healthy than the population eligible for the new adult coverage group.
- The demonstration claims data does not include utilization for essential health benefits that were not covered by the demonstration benefit package. For example, because HIP does not cover benefits such as maternity care or vision, utilization of such benefits in the demonstration claims data is zero. This does not allow us to estimate the actuarial value of these benefits for benchmark plans that offer these services.

The alternative we chose was to use ***Milliman Health Cost Guidelines*** data.

The ***Guidelines*** were first developed by Milliman in 1954, and have been updated and expanded annually since that time. An extensive amount of data is used in developing the Guidelines, including published and unpublished data. The ***Guidelines*** was developed from full medical experience (hospital, physician, supplies, prescription drugs) from over 21 million lives. This is supplemented by other sources for specific services, for example a database of inpatient admissions that represents 75% of the national total.

Base utilization levels in the ***Guidelines*** are consistent with a commercial major medical plan. The utilization is summarized by age and gender, and is easily adjusted to the approximate age and gender makeup of those eligible for the new adult coverage group. Utilization is available for every service that may be offered by a benchmark plan.

Methodology

The actuarial value of the HIP demonstration and each benchmark plan was developed using a common actuarial cost model. High level results from this model are illustrated in Appendix B. The summaries illustrate all the key elements by category of service: utilization, cost per service, per member per month cost, and cost sharing value. For each service, the model illustrates estimated utilization (column 1) and average allowed cost per service (2). These are multiplied to develop the total per member per month (3) cost of benefits for each service. Through column 3, the results are identical for the demonstration and three benchmark plans. The total per member per month cost of $280.52 represents the cost

of essential health benefit coverage for the standardized population at a Medicare reimbursement. This is the denominator for each aggregate actuarial value calculation.

Column 4 illustrates the value of member cost sharing. As an example, when the plan requires the member to contribute 20% coinsurance, the cost sharing will be approximately 20% of the total value in column 3. In cases where the benefit was not covered in December 2009, the cost sharing will be equal to the total value in column 3 (for example maternity benefits for the demonstration). Column 5 illustrates the net value provided by the plan. The net per member per month cost for all services is developed by adding the cost for each individual service.

Finally, cost sharing provisions that apply across multiple service categories, such as deductibles or out of pocket maximums, are reflected. After adjustment for global cost sharing, the net per member per month cost illustrates the value provided by the plan.

The actuarial value for each plan is developed by dividing the value of benefits provided by the plan by the total per member per month cost for covering all essential health benefits ($280.52).

Demographics

The cost models used standard utilization, developed based on the ***Milliman Health Cost Guidelines*** data, with adjustment for the estimated demographics of the new adult coverage group in Indiana. This group is aged 19 to 64, with age and gender distribution as illustrated in Table 3 below.

Table 3

Age/Gender Distribution - New Adult Coverage Group

Age Bracket	Male	Female
19-25	12%	11%
25-29	6%	6%
30-34	5%	6%
35-39	4%	5%
40-45	4%	6%
45-49	4%	4%
50-54	5%	4%
54-59	3%	4%
60-64	4%	6%

Those eligible for the new adult coverage group were estimated based on 2011 American Community Survey data from the U.S. census bureau. We selected individuals aged 19 – 64 who were not already covered by Medicare or Medicaid and had incomes below 138% of poverty guidelines. Also excluded were individuals in group quarters: college students, nursing home residents, and incarcerated individuals. We have found that college students often appear to have improperly low incomes because they have not been grouped with their parents. And finally, the estimated new adult coverage group also excludes adults who are currently eligible for Medicaid but enrolled: custodial adults with incomes below the AFDC income limits.

Pricing and Other Assumptions

Pricing in the models has been adjusted to Medicare levels for all plans. This is the pricing level used for the HIP demonstration. Pharmacy reimbursement has been assumed to be the Average Wholesale Price (AWP) less 18% for brand name drugs, and AWP less 65% for generics. A $2 dispensing fee has also been incorporated in the cost.

No adjustment has been made to reflect differing degrees of health care management, including utilization control, prior authorizations, or other delivery system variations.

Cost sharing provisions for each plan are reflected in the models.

Analysis of Results

In general, the benchmark plans covered a wider range of services, most notably maternity benefits.

Adjustments for the value of the cost sharing did not change the relative positions of the plans. Although the benchmark plans have higher copays and coinsurance, the demonstration has the highest deductible.

The remainder of this section discusses the actuarial value by category of service. Please refer to the actuarial cost model summaries in Appendix B.

Inpatient Facility benefits

As for all services, utilization (column 1), average allowed cost (2) and total per member per month cost (3) are the same for all plans. The total monthly value of these services before cost sharing is estimated as $46.09 for all plans.

The benchmark plans had relatively low cost sharing for this category of service:

- The FEHBP required a $200 copay per admission. The copay is waived for maternity admissions.
- The State employee plan required a $500 copay per admission.
- The HMO required a $250 copay per admission.
- The HIP demonstration did not cover maternity services. This is illustrated as 100% cost sharing for this service line. There are no other copay or coinsurance requirements for inpatient hospital services. However, these services were subject to the $1,100 deductible.

Outpatient Facility benefits

The total monthly value of outpatient facility services before cost sharing is estimated as $60.18 for all plans.

Cost sharing is reflected as follows:

- The FEHBP required 15% coinsurance
- The State employee PPO required $75 copays for emergency room services, $250 copays for outpatient surgery, and 20% coinsurance applied to other services.
- The HMO required $125 copays for outpatient surgery and emergency room visits, $35 copays for therapy, mental health, and substance abuse visits, and an additional $50 copay for certain types of imaging. Other services were subject to 20% coinsurance.
- The HIP demonstration required a $3 to $25 copay for emergency room services. Also, all costs other than preventive services were subject to the deductible.

Professional

The total monthly value of professional services before cost sharing is estimated as $76.41 for all plans.

Cost sharing generally reflected a mixture of copays and coinsurance and can be summarized as follows:

- The FEHBP required $20 copays for most office visits, and 15% coinsurance for other services. Cost sharing was waived for maternity services.
- The State employee PPO required $20 copays for office visits, and 20% coinsurance applied to other services. Cost sharing was waived for preventive services.
- The Advantage HMO did not cover chiropractic services. These are illustrated as 100% patient responsibility. In general, the HMO applied $20/$35 primary care/specialist copays to office visits, including mental health and substance abuse visits, with $50 copays for urgent care visits. 20% coinsurance applied to other services. Cost sharing is reduced for maternity services (only applies to the first prenatal visit).
- The HIP demonstration did not cover maternity or chiropractic services. These are illustrated as 100% patient responsibility. Also, all costs other than preventive services were subject to the $1,100 deductible.

Other

The total monthly value of professional services before cost sharing is estimated as $97.84 for all plans, mainly attributable to prescription drugs.

Prescription drug cost sharing provisions can be summarized as follows:

- When purchased retail, the FEHBP required 20% coinsurance for generics and 30% for brand drugs. Mail order purchases allowed for a 90-day supply: $10 for generics and $65 for brand name drugs. We have assumed an even mix of purchase types (mail order/retail).
- The State employee PPO required $10 copays for generic drugs, $20 for brand drugs.
- The Advantage HMO required $10 or $20 copays for generic drugs and $30 for brand drugs.
- The HIP demonstration had no copays for drugs. They were subject to the $1,100 deductible.

The HIP demonstration did not provide dental or vision benefits. The benchmark plans covered a minimal level of vision and dental benefits in order to cover accidental injury or glasses needed for a medical condition. The benchmark plans also subsidize stand-alone supplemental vision and benefit plans for members, but these are not valued as part of this analysis.

Global Cost Sharing Adjustments

The value of global cost sharing provisions, such as deductibles and out of pocket maximums, was developed using a claims probability distribution. Although average per member per month values are illustrated for each service, the majority of members do not incur any claims at all during a given month, and those members who do incur claims tend to incur costs that are higher than the average.

The deductible serves to shift a portion of first dollar costs from the plan to the member, reducing actuarial value. It has a greater impact for HIP demonstration members than for benchmark plan members. This is because:

- Except for preventive services, all demonstration services are subject to the deductible. The benchmark plans have many commonly provided services, most notably hospital, prescription drugs and office visits, that are not subject to the deductible because they are subject to copays instead.
- The demonstration's deductible is higher than for the other plans.

The out of pocket maximum serves to protect members who incur large costs, adding to the value of the plan. The value of this provision is largest for the State PPO, as their members only have to incur $2,000 in out of pocket expenses - $500 deductible plus $1,500 additional – before the out of pocket maximum kicks in. It is less valuable for the FEHBP, whose members need to pay $5,000 out of pocket before the maximum is reached. And it has almost no value at all for HIP demonstration members because after the $1,100 deductible has been paid, there are no additional opportunities for cost sharing (no other copays or coinsurance except for a minimal copay related to emergency services.)

SECTION II – BENEFIT ASSESSMENT TO SUBSTANTIATE EXPANSION STATE FMAP

In the previous section, the State of Indiana has determined that the Healthy Indiana Plan (HIP) section 1115 demonstration did not provide full benefits, benchmark benefits, or benchmark equivalent benefits. The State has not prepared a response to Section II due to the results of the analysis presented in Section I.

CERTIFICATE OF ACTUARIAL VALUE OF THE DEMONSTRATION PACKAGE

ACTUARIAL CERTIFICATION

The authors of this study, Robert Damler, and Christine Mytelka, are consulting actuaries with the firm of Milliman, Inc. We were retained by the State of Indiana, Office of Medicaid Policy and Planning, to perform a benchmark equivalent coverage analysis for the Healthy Indiana Plan (HIP) demonstration.

The study was performed in accordance with generally accepted actuarial principles and methodologies. All Actuarial Standards of Practice promulgated by the Actuarial Standards Board have been observed.

The study uses a standardized set of utilization and price factors for the demonstration plan and the benchmarks. The utilization is representative of an adult commercial population, and Medicare pricing was used.

The study uses a standardized population for evaluating the demonstration plan and the benchmarks. A non-Medicare adult population was used, with standard age and gender distribution. Coverage is assumed to be self-only (no family or dependent coverage).

The demonstration was compared to the benchmarks using the same principles and factors in comparing the value of different coverage. The same actuarial cost model was used for all plans, modified only to reflect different plan provisions, such as benefits covered, benefit limitations, and cost sharing provisions.

The analysis does not take into account any differences in coverage based on method of delivery or means of cost control or utilization used.

The analysis reflects the increase in actuarial value of benefits resulting from limitations on cost sharing.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

ELECTRONIC SIGNATURE

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

March 26, 2013
Date

Electronic Signature

Christine Mytelka, FSA, MAAA
Consulting Actuary

March 26, 2013
Date

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration and Office of Medicaid Policy and Planning (OMPP), to assist with submitting benefit information associated with the Healthy Indiana Plan 1115 demonstration to the Centers for Medicare and Medicaid Services (CMS). The data and information presented may not be appropriate for any other purpose.

The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for OMPP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the State of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and OMPP approved May 14, 2010.

Appendix A

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Financial Management Group

FEB 15 2013

Patricia Casanova
Director
Office of Medicaid Policy and Planning
Family and Social Services Administration
402 West Washington Street, PO Box 7083
Indianapolis, IN 46207-7083

Dear Ms. Casanova:

CMS recently issued Questions and Answers, which can be found at http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf, to provide states with more information about the availability of increased federal medical assistance percentages (FMAPs, or federal match) provided in the Affordable Care Act. We are writing to provide additional guidance to Indiana on the availability of the "newly eligible" and/or "expansion state" FMAP given that Indiana provided coverage to low-income adults through its Healthy Indiana Plan (HIP) section 1115 demonstration prior to the enactment of the Affordable Care Act. Specifically, we wanted to describe how we will work with you to determine whether demonstration populations will be eligible for the newly eligible, expansion state or regular FMAP, if your state decides to adopt the new adult coverage group. More guidance about the method states will use to distinguish among populations for purposes of applying the appropriate FMAP will be provided in forthcoming FMAP final regulations.

As you know, beginning in 2014 the Affordable Care Act authorizes two types of increased federal Medicaid matching rates for state expenditures for low-income individuals in the new adult group (that is, the group described by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act)): the newly eligible FMAP and the expansion state FMAP. Under the statute, these two increased federal matching rates are only available to states that adopt the new adult group.

- The newly eligible FMAP is available to all states, including those identified as expansion states, for expenditures for individuals in the new adult group who would not be eligible for full state plan, benchmark, or benchmark-equivalent Medicaid benefits under state rules in effect as of December 1, 2009. This includes expenditures for individuals that would have been eligible for such coverage, but were not enrolled due to enrollment limitations under the demonstration.
- The expansion state FMAP is available to qualifying states for expenditures for certain nonpregnant childless adults (those who are enrolled in the new adult group and who the state may require to enroll in benchmark coverage), to the

extent that such individuals do not qualify for the newly eligible FMAP. A qualifying state is a state that, as of March 23, 2010 (the date of enactment of the Affordable Care Act), had provided a specified level of health benefits coverage, which we refer to as "specified" coverage,[1] (whether through Medicaid or a fully state-funded program) statewide to both low-income parents and nonpregnant childless adults up to at least 100 percent of the federal poverty level (FPL).

The newly eligible and expansion state FMAP definitions reference different coverage dates and different scopes of benefits, thus requiring different analyses to confirm their application. To the extent that the definitions overlap for a particular population, so that either the newly eligible or the expansion state FMAP could apply in a state designated as an expansion state, expenditures would be matched at the higher applicable FMAP; being an expansion state will not be a disadvantage in terms of matching rates for that population. It is important to also note that the expenditures for some populations in the new adult group (for example, parents who were previously eligible for full state plan benefits) may be matched at your regular FMAP.

We will work with you and your staff to ensure that the correct FMAP is applied to expenditures for each population. When we approved the HIP demonstration, we did not explicitly designate the coverage offered under your accepted Special Terms and Conditions (STCs) as "benchmark" or "benchmark-equivalent" coverage, even though the coverage offered to demonstration beneficiaries may have met such standards. Therefore, to reach a final FMAP determination for your state, we are requesting that you provide certifications about eligibility and benefits in effect as of dates specified in the Affordable Care Act.

In particular, we request that you provide a benefit analysis that includes the information described in Attachment A to enable CMS to confirm whether coverage provided to each demonstration population as of December 1, 2009 represents "full benefits," "benchmark," or "benchmark-equivalent" coverage. (Additional information on the statutory benchmark standards that were in effect on December 1, 2009 can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Benchmark-Standards-12-1-09.pdf). If the demonstration coverage is found not to have met a benchmark or benchmark-equivalent coverage standard, Indiana will qualify for the newly eligible FMAP for relevant populations. As noted above, Attachment A provides a guide for you and your staff to use to as you conduct your benefit analyses. Completion of the guide is not required as it is merely a form to use at your option; however, the type of information contained in it is needed for CMS to confirm your applicable FMAPs.

If the newly eligible FMAP is not available for a particular population, you may be able to claim the expansion state FMAP for certain nonpregnant childless adults covered in

[1] The standards for specified coverage are set forth in section 1905(z)(3) of the Act statewide; it is coverage that included inpatient hospital services, was not dependent on access to employer coverage, employer contribution, or employment, and was not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits authorized under a demonstration program authorized under section 1938 of the Act.

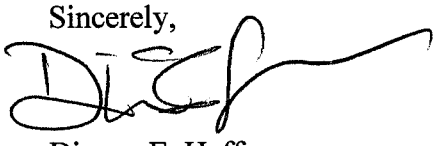
the new adult group. The benefit analysis described in Attachment A is necessary for you to establish Indiana's status as an expansion state so that we can apply the expansion state FMAP to appropriate expenditures. As noted above, status as an expansion state will not negatively affect your ability to claim the newly eligible FMAP. The expansion state FMAP will apply only when the newly eligible FMAP is not applicable for a particular population.

Attachment A provides additional detail about the methodology and data necessary to substantiate your analysis. For example, the state's benchmark equivalence analyses must be certified by a qualified actuary and must include information on the data, assumptions, and methodology used to calculate actuarial values, as described in Attachment A. We will use the benefit analyses information provided to determine the appropriate FMAP. Upon reviewing your benefit analyses, we may seek additional information and/or clarification.

Given that Indiana expanded coverage prior to the enactment of the Affordable Care Act, we encourage you to analyze your demonstration's benefits using the guide found in Attachment A and to submit your analyses to CMS. We understand that you may have not made a decision about whether and/or when to adopt the new adult coverage category and submission of your analysis will not obligate Indiana to any particular decision. Rather, providing this information will enable CMS to provide you with information about the FMAP(s) that might apply depending on the state's decision.

We are committed to reviewing your information and working with you and your staff to confirm the applicable FMAPs in a timely manner. We encourage you to submit your analysis to Allison Orris at Allison.Orris@cms.hhs.gov by April 15, 2013. Please work with your State Operations and Technical Assistance (SOTA) team, or contact Allison Orris if you have any questions.

Sincerely,



Dianne E. Heffron
Director
Financial Management Group

Attachment

Attachment A: Guide to Demonstration Benefit Analysis

cc:

Verlon Johnson, Associate Regional Administrator, Division of Medicaid and Children's Health Operations

Barbara Edwards, Director, Disabled and Elderly Health Programs Group

Jennifer Ryan, Acting Director, Children and Adults Health Programs Group

Attachment A - Guide to Demonstration Benefit Analysis

This Attachment provides a guide for the state to use to conduct the benefit analysis for purposes of determining which FMAPs may apply for adult populations provided coverage through section 1115 demonstrations prior to enactment of the Affordable Care Act. Use of this guide is not required; however, the information contained below will help CMS to confirm the applicable FMAPs. A separate analysis should be undertaken for each demonstration group, if different demonstration populations received different benefits under the demonstration and/or if different enrollment caps or limitations applied to different groups. CMS may request additional information to address specific questions; the below questions represent a uniform starting point for analysis.

Section I – Benefit Assessment to Substantiate Newly Eligible FMAP

The newly eligible FMAP is only available to states that did *not* provide "full state plan benefits," "benchmark" or "benchmark-equivalent" coverage to low-income adults either through the Medicaid state plan or through a section 1115 demonstration. To determine if demonstration-based coverage could have been designated as benchmark or benchmark-equivalent coverage, the following questions (based on section 1937 of the Act, as it was in effect on December 1, 2009, and our regulation at 42 CFR 440.330-340) should be considered as part of the state's analysis.

> According to our preliminary review, on December 1, 2009, the state provided coverage to uninsured custodial parents and caretaker relatives with income above the AFDC income limit up to and including 200 percent of the federal poverty level (FPL) and uninsured non-custodial parents and childless adults (ages 19 through 64) with family income up to 200 percent of the FPL through the Healthy Indiana Plan demonstration (Project Number 11-W-00237/5). If this is incorrect, please provide the correct demonstration name, project number and/or covered populations.

1. Was the demonstration, as in effect on December 1, 2009, authorized to limit enrollment?

> If applicable, please specify the enrollment cap authorized by the demonstration as of December 1, 2009, and the actual enrollment, as calculated per the reporting requirements specified under the demonstration, if different.

2. **Full Benefits:** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "full benefits" meaning, with respect to each demonstration group, medical assistance for all services covered under the state's approved Medicaid state plan?

[If the answer to question 2 is "yes," skip to Section II to establish whether "expansion state" status is applicable.]

3. **"Benchmark Coverage":** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "benchmark coverage" described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act? Please answer the following questions to support this representation, and include any applicable citations to the demonstration's special terms and conditions (STCs) that were in effect on December 1, 2009:

3a. Did the demonstration benefit package include the entire range of services offered under any of the following three commercial products, as they were in effect on December 1, 2009? (States that are unable to locate health plan information from 2009 should contact CMS for technical assistance.)

i. The standard Blue Cross/ Blue Shield preferred provider option;
ii. A health benefits coverage plan that is offered and generally available to state employees in that state; or
iii. The health insurance coverage offered by a Health Maintenance Organization with the largest insured non-Medicaid enrollment of covered lives.

[If the answer to question 3a is "no," continue to question 4.]

4. **"Benchmark Equivalent Coverage":** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "benchmark equivalent coverage" described in section 1937(b)(2) of the Act that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in (A), (B), or (C) of section 1937(b)(1) of the Act? Please answer the following questions to support this representation:

4a. Did the demonstration benefit package provide all of the following services?

i. Inpatient and outpatient hospital,
ii. Physicians' surgical and medical services,
iii. Lab and x-ray services, and
iv. Emergency services, as required in 42 CFR 440.335(b)(5)

4b. In addition to the services mentioned above, did the demonstration benefit package have an aggregate actuarial value that is at least actuarially equivalent to one of the three following commercial products:

i. The standard Blue Cross/ Blue Shield preferred provider option;
ii. A health benefits coverage plan that is offered and generally available to state employees in that state; or
iii. The health insurance coverage offered by a Health Maintenance Organization with the largest insured non-Medicaid enrollment of covered lives.

4d. If the commercial product selected for actuarial comparison contained prescriptions drugs, mental health services, vision or hearing services as of December 1, 2009, did the demonstration benefit package offer such coverage to have an actuarial value of at least 75 percent of the actuarial value of the coverage

for that category of service in the benchmark plan used for comparison by the state?

4e. Has the state obtained a certificate of actuarial value of the demonstration benefit package adhering to the requirements above, completed by an individual who is a member of the American Academy of Actuaries, and that meets the following elements?

i. Uses generally accepted actuarial principles and methodologies;
ii. Uses a standardized set of utilization and price factors;
iii. Uses a standardized population that is representative of the population involved;
iv. Applies the same principles and factors in comparing the value of different coverage (or categories of services);
v. Does not take into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
vi. Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage. This is important especially since Medicaid typically has minimal or no cost sharing requirements (even if they may be more extensive in waiver plans) while the benchmark plans may have higher levels of cost sharing.

In conducting the foregoing analysis, it will be important to utilize a consistent methodology and provide CMS with sufficient data to substantiate the states' conclusions. Following the below guidelines will assure CMS' ability to validate states' analysis:

- The analysis should specify the source of data used to calculate the actuarial value of the plans. We recommend using recent actual claims experience from beneficiaries in the demonstration to conduct the analysis. If other data is used, the data should be for a comparable population (which may include age, gender, geography, and health and disability status amongst other factors); the report should also state why this data source was used.

- The methodology to calculate actuarial value and equivalence should also be specified in the analysis. The following factors should be considered in the methodology:
  - The methodology should use a standard set of prices or reimbursement rates for the different plans. In other words, the differences between the prices paid between the plans should not be considered as a source of difference in actuarial value between the plans.
  - The methodology should consider differences between the cost sharing requirements of the plans. The actuarial value should be based on the

value of the benefits paid by the plan rather than on the value of the allowed benefits of the plans.
  - The methodology should also consider other relevant differences between the plans. This should include differences in values that result from benefits offered in the demonstration plan and not in the benchmark plans and vice versa (benefits offered in the benchmark plans but not in the demonstration plan).

- When determining whether the demonstration plan, as in effect on December 1, 2009, and the benchmark plans are actuarially equivalent, we consider a plan that has an actuarial value equal to another plan's value plus or minus 2 percent to be actuarially equivalent. This standard, which we are adopting for benchmark equivalence comparisons for purposes of assigning the newly eligible FMAP only, is based on and consistent with the November 26, 2012 proposed rule "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation." The Center for Consumer Information and Insurance Oversight proposes to apply this +/- 2 percent *de minimis* standard to determine whether plans that will be offered on Affordable Insurance Exchanges are actuarially equivalent. Because measuring the actuarial value of plans may not be precise, particularly in cases where there are significant differences in the benefits and plan design between the demonstration plan and the benchmark plans, it is reasonable to allow for a range around the actuarial values of the plan rather than require a precise equality.

In communicating the results of this analysis, you should submit a report certified by an actuary (as described above) that contains at a minimum the following information:

- The data used in the analysis;
- The methodology used in the analysis;
- The actuarial values of the demonstration plan and the benchmark plans, and;
- An analysis of the differences in actuarial values of the demonstration plan and the benchmark plans if the demonstration plan is found not to be at least actuarially equivalent to the benchmark plans. This analysis should discuss the main reasons for the differences (for example, differences in services covered; differences in cost sharing and plan design; other key differences between the plans) as well as the relative contribution of the major differences between the plans.

Finally, as noted above, for demonstrations that have separate populations and benefit plans, an analysis should be provided for each population or plan. These analyses may be presented within the same report or in separate reports.

Section II – Benefit Assessment to Substantiate Expansion State FMAP

If, after completing the newly eligible benefit assessment described above, you determine that full benefits, benchmark benefits, or benchmark equivalent benefits were provided, and that the newly eligible FMAP is therefore not available for some or all demonstration

populations, you should answer the following questions in order to substantiate possible eligibility for the expansion state FMAP, if applicable.

In answering the questions below, please cite the applicable STC or state-based policy.

1. Did Indiana provide coverage to parents and childless adults up to at least 100 percent of poverty, as of March 23, 2010?

   If Indiana did provide coverage, please answer questions (a) through (c) below:

   a. What was the upper income level of coverage for parents as of March 23, 2010? How many people received such coverage?

   b. What was the upper income level for coverage of childless adults as of March 23, 2010? How many people received such coverage?

   c. If coverage was provided through a section 1115 demonstration, please provide the demonstration's name and project number; if through a state-only program, please identify the state-only program.

2. Was this coverage offered on a statewide basis?

3. What was the scope of coverage provided to these populations?

   a. Did the coverage include inpatient hospital services?

   b. Was the coverage dependent on access to employer coverage, employer contribution, or employment?

   c. Was the coverage limited to premium assistance, hospital-only benefits, a high deductible health plan, or a health opportunity account?

Appendix B

Indiana Medicaid

FEHB Plan - Standard Option
$300 Deductible / 15% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.37	$12.48	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.31	24.27	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.09	1.71	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.00	6.36	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$0.77	$45.32	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$1.19	$10.70	
Surgery			142 cases	1,934.79	22.90	3.43	19.47	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	1.76	10.02	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.06	0.35	
Preventive			329 cases	54.83	1.50	0.23	1.27	
Other Outpatient Facility			582 cases	241.40	11.70	1.85	9.85	
					$60.18	$8.52	$51.66	
Professional								
Surgery			746 proced	$360.78	$22.43	$3.36	$19.07	
Maternity			50.0 proced	784.51	3.26	0.00	3.26	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	4.42	5.53	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.19	5.93	
Preventive			1,394 proced	32.04	3.72	2.32	1.40	
Consults			862 visits	90.63	6.50	0.85	5.65	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	1.21	1.44	
Hearing and Speech Exams			21 visits	51.35	0.09	0.01	0.08	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	2.64	14.92	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	1.03	1.17	
					$76.41	$17.96	$58.45	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$16.51	$75.25	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.09	0.54	
Ambulance			22 cases	737.04	1.35	0.14	1.21	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.42	2.42	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.86	0.29	
Other - Total					$97.84	$18.04	$79.80	
Total Medical Cost					$280.52	$45.29	$235.23	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$100.03	
Value of $300 Deductible							(9.87)	
Value of $4,700 Out-of-Pocket Maximum after deductible							8.02	
Value of $9,999,999 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$98.18	
PMPM for Services Not Subject to Deductible							$135.20	
Total Medical Cost After Deductible and Coinsurance							$233.38	83.2%

Prescription Drugs	$75.25	$91.76	82.0%
Mental Health Services	3.23	4.41	73.2%
Vision	0.09	0.11	81.8%
Hearing	0.08	0.09	88.9%

Indiana Medicaid

State Employee PPO
$500 Deductible / 20% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.93	$11.92	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.78	23.80	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.22	1.58	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.81	5.55	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.05	0.45	
	66.7 Admits	4.96	330.9 days		$46.09	$2.79	$43.30	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$1.31	$10.58	
Surgery			142 cases	1,934.79	22.90	2.96	19.94	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	2.35	9.43	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.09	0.32	
Preventive			329 cases	54.83	1.50	0.30	1.20	
Other Outpatient Facility			582 cases	241.40	11.70	2.34	9.36	
					$60.18	$9.35	$50.83	
Professional								
Surgery			746 proced	$360.78	$22.43	$4.49	$17.94	
Maternity			50.0 proced	784.51	3.26	0.65	2.61	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	4.57	5.38	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.43	5.69	
Preventive			1,394 proced	32.04	3.72	0.74	2.98	
Consults			862 visits	90.63	6.50	0.83	5.67	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	0.53	2.12	
Hearing and Speech Exams			21 visits	51.35	0.09	0.02	0.07	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	3.52	14.04	
Chiropractor			564 visits	19.82	0.93	0.19	0.74	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	0.44	1.76	
					$76.41	$17.41	$59.00	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$6.37	$85.39	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.07	0.56	
Ambulance			22 cases	737.04	1.35	0.09	1.26	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.57	2.27	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.31	0.84	
Other - Total					$97.84	$7.43	$90.41	
Total Medical Cost					$280.52	$36.98	$243.54	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$73.66	
Value of $500 Deductible							(12.15)	
Value of $1,500 Out-of-Pocket Maximum after deductible							10.72	
Value of $2,000,000 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$72.23	
PMPM for Services Not Subject to Deductible							$169.88	
Total Medical Cost After Deductible and Coinsurance							$242.11	86.3%

Prescription Drugs	$85.39	$91.76	93.1%
Mental Health Services	3.66	4.41	83.0%
Vision	0.09	0.11	81.8%
Hearing	0.07	0.09	77.8%

Company Name

Advantage HMO
$250 Deductible / 50% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.46	$12.39	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.39	24.19	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.11	1.69	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.40	5.96	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$1.36	$44.73	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$2.18	$9.71	
Surgery			142 cases	1,934.79	22.90	1.48	21.42	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	0.28	11.50	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.18	0.23	
Preventive			329 cases	54.83	1.50	0.00	1.50	
Other Outpatient Facility			582 cases	241.40	11.70	1.35	10.35	
					$60.18	$5.47	$54.71	
Professional								
Surgery			746 proced	$360.78	$22.43	$0.00	$22.43	
Maternity			50.0 proced	784.51	3.26	0.04	3.22	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	5.81	4.14	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.07	6.05	
Preventive			1,394 proced	32.04	3.72	0.00	3.72	
Consults			862 visits	90.63	6.50	0.35	6.15	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	2.11	0.54	
Hearing and Speech Exams			21 visits	51.35	0.09	0.00	0.09	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	0.00	17.56	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	1.72	0.48	
					$76.41	$12.03	$64.38	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$16.90	$74.86	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.00	0.63	
Ambulance			22 cases	737.04	1.35	0.27	1.08	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	1.42	1.42	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.39	0.76	
Other - Total					$97.84	$19.00	$78.84	
Total Medical Cost					$280.52	$37.86	$242.66	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$28.94	
Value of $250 Deductible							(8.69)	
Value of $0 Out-of-Pocket Maximum after deductible							0.00	
Value of $9,999,999 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$20.25	
PMPM for Services Not Subject to Deductible							$213.72	
Total Medical Cost After Deductible and Coinsurance							$233.97	83.4%

Prescription Drugs	$74.86	$91.76	81.6%
Mental Health Services	2.40	4.41	54.4%
Vision	0.09	0.11	81.8%
Hearing	0.09	0.09	100.0%

Indiana Medicaid

Healthy Indiana Plan Demonstration

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost
Inpatient Facility							
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.00	$12.85
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.00	24.58
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.00	1.80
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	6.36	0.00
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50
	66.7 Admits	4.96	330.9 days		$46.09	$6.36	$39.73
Outpatient Facility							
Emergency Room			209 cases	$682.75	$11.89	$0.05	$11.84
Surgery			142 cases	1,934.79	22.90	0.00	22.90
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	0.00	11.78
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.00	0.41
Preventive			329 cases	54.83	1.50	0.00	1.50
Other Outpatient Facility			582 cases	241.40	11.70	0.00	11.70
					$60.18	$0.05	$60.13
Professional							
Surgery			746 proced	$360.78	$22.43	$0.00	$22.43
Maternity			50 proced	784.51	3.26	3.26	0.00
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	0.00	9.95
Miscellaneous Medical			1,642 proced	51.98	7.12	0.00	7.12
Preventive			1,394 proced	32.04	3.72	0.00	3.72
Consults			862 visits	90.63	6.50	0.00	6.50
Vision			0 visits	0.00	0.00	0.00	0.00
Physical Therapy			723 visits	44.00	2.65	0.00	2.65
Hearing and Speech Exams			21 visits	51.35	0.09	0.00	0.09
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	0.00	17.56
Chiropractor			564 visits	19.82	0.93	0.93	0.00
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	0.00	2.20
					$76.41	$4.19	$72.22
Other							
Prescription Drugs			12,122 scripts	$90.84	$91.76	$0.00	$91.76
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.00	0.63
Ambulance			22 cases	737.04	1.35	0.00	1.35
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.00	2.84
Glasses/Contacts			10 cases	135.60	0.11	0.11	0.00
Dental Benefits			133 cases	104.07	1.15	1.15	0.00
Other - Total					$97.84	$1.26	$96.58
Total Medical Cost					$280.52	$11.86	$268.66
Starting Net PMPM Claim Cost for Services Subj to Ded.							$264.60
Value of $1,100 Deductible							(55.26)
Value of $0 Out-of-Pocket Maximum after deductible							0.00
Value of $300,000 Annual Maximum							(2.61)
Adjusted Net PMPM for Services Subject to Deductible							$206.73
PMPM for Services Not Subject to Deductible							$4.06
Total Medical Cost After Deductible and Coinsurance							$210.79 75.1%

Prescription Drugs	$91.76	$91.76	100.0%
Mental Health Services	4.41	4.41	100.0%
Vision	0.00	0.11	0.0%
Hearing	0.09	0.09	100.0%

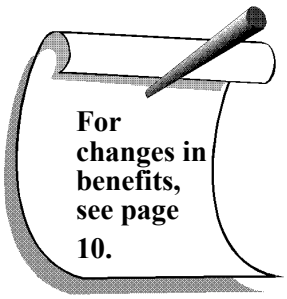
Appendix C

Blue Cross® and Blue Shield® Service Benefit Plan

http://www.fepblue.org

2009

A fee-for-service plan (standard and basic option) with a preferred provider organization



Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHB

Enrollment codes for this Plan:

104 Standard Option - Self Only
105 Standard Option - Self and Family
111 Basic Option - Self Only
112 Basic Option - Self and Family

ACCREDITED HEALTH WEB SITE

ACCREDITED CASE MANAGEMENT

This Plan has Health Web Site and Case Management accreditation from URAC. See the 2009 FEHB Guide for more information on accreditation.

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Center for Retirement and Insurance Services
http://www.opm.gov/insure

RI 71-005

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of the Blue Cross and Blue Shield Association (the Carrier). The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street, NW, Suite 900
Washington, DC 20005

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on pages 9 and 10. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-FEP-8440 (1-800-337-8440) and explain the situation.

If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

Ø www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this fee-for-service Plan

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are "Preferred providers." When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also go to our Web page, www.fepblue.org, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact your Local Plan to request a PPO directory.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (Non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. We refer to PPO facility and professional providers as "Preferred." They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under Standard Option only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. If they are professionals, we refer to them as "Participating" providers. If they are facilities, we refer to them as "Member" facilities. They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as "Non-participating providers" generally, although if they are facilities we refer to them as "Non-member facilities."** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see page 124). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 14 for the exceptions to this requirement.

Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

General features of our High Deductible Health Plan (HDHP)

The Blue Cross and Blue Shield Service Benefit Plan Basic Option includes a sub-option called Basic Consumer Option. This High Deductible Health Plan (HDHP) is available to members who reside in Ohio; Minnesota; Tennessee; the counties of Johnson and Wyandotte in Kansas; and, in the following counties of Missouri: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, and Worth. As with other FEHB HDHPs, our Basic Consumer Option features a calendar year deductible and an annual out-of-pocket maximum limit that are higher than other types of FEHB plans. Also, as with other FEHB Program HDHPs, our Basic Consumer Option also offers tax-favored Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs). Please see below for more information about these savings features. For detailed information about the Basic Consumer Option, please refer to the *Addendum Summarizing the Basic Consumer Option Program.*

Preventive care services

Under Basic Consumer Option, preventive care services performed by Preferred providers are paid as first dollar coverage, i. e., you pay nothing for covered services. You must use Preferred providers in order to receive benefits. See page 14 of the Service Benefit Plan brochure for the exceptions to this requirement.

Annual deductible

You must meet the Basic Consumer Option calendar year deductible before we provide benefits for non-preventive medical care. The annual deductible is $2,900 for Self Only coverage and $5,800 for Self and Family coverage.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), are not enrolled in Medicare, have not received VA benefits within the last three months, are not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- You cannot make contributions to an HRA.
- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket maximum amount for covered services is the same as your annual deductible amount: $2,900 for Self Only coverage and $5,800 for Self and Family coverage. Therefore, if you have met your annual deductible, you have also satisfied your annual maximum for out-of-pocket expenses. Your care must be provided by Preferred providers (and Non-preferred providers that meet the exception situations listed in this brochure).

Health education resources and accounts management tools

You can find information about Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) on our Web site at www.fepblue.org. You can also access your HSA or HRA account balance in addition to your complete claims reimbursement payment history from Blue Healthcare Bank through our Web site. Blue Health Connection offers health advice and counseling in addition to information on general health topics, health care news, specific diseases, first aid, drug/medication interactions, children's health, and patient safety. You may contact Blue Health Connection by calling 1-888-258-3432 toll-free, or accessing our Web site, www.fepblue.org.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Care management, including medical practice guidelines;
- Disease management programs; and
- How we determine if procedures are experimental or investigational.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our Web site at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Section 2. How we change for 2009

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (Benefits). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- In Section 3, under **Covered professional providers**, Illinois has been added to the list of medically underserved areas for 2009. (See page 12.)

Changes to this Plan

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 134.)
- Your $10 copayment for generic drugs purchased through the Mail Service Prescription Drug Program is now waived for the first 4 generic prescriptions filled (and/or refills ordered) per calendar year. (See page 92.)
- Your coinsurance amount for generic drugs purchased at Preferred Retail Pharmacies is now 20% of the Plan allowance. In addition, your coinsurance amount for brand-name drugs is now 30% of the Plan allowance. Previously, you paid 25% of the Plan allowance for generic drugs and 25% of the Plan allowance for brand-name drugs. (See page 91.)
- We clarified that Prescription Drug Benefits are available for diabetic test strips. (See page 90.)
- Your copayment for brand-name drugs purchased through the Mail Service Prescription Drug Program is now $65 per prescription for the first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year and $50 per brand-name prescription/refill thereafter. Previously, your copayment was $35 per brand-name prescription. (See page 92.)
- The catastrophic out-of-pocket maximum for deductibles, coinsurance, and copayments is now $5,000 per year when you use Preferred providers and $7,000 per year when you use a combination of Preferred and Non-preferred providers. Previously, the out-of-pocket maximum was $4,500 for Preferred provider services and $6,500 for both Preferred and Non-preferred provider services. (See page 21.)
- You now pay 15% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, pathologists, and assistant surgeons (including assistant surgeons in a physician's office). You are also responsible for any difference between our allowance and the billed amount. Previously, you paid 10% of the Plan allowance. (See pages 28 and 51.)
- Your copayment for office visits to Preferred providers is now $20 per visit. Previously, you paid $15 per visit. [See Sections 5(a), 5(d), and 5(e).]
- Your coinsurance amount for office visits to Non-preferred providers is now 30% of the Plan allowance. Previously, you paid 25% of the Plan allowance. [See Sections 5(a), 5(d), and 5(e).]
- Your coinsurance amount for certain Preferred professional services is now 15% of the Plan allowance. In addition, your coinsurance amount for certain Non-preferred professional services is now 30% of the Plan allowance. Previously, you paid 10% of the Plan allowance for Preferred provider services and 25% of the Plan allowance for Non-preferred provider services. [See Sections 5(a), 5(b), 5(d), and 5(e).]
- You may now receive specific benefit information in advance about non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be $5,000 or more. (See page 17.)
- You now pay 100% of the billed amount up to a maximum of $800 for anesthesia provided by a Non-participating anesthesiologist or certified registered nurse anesthetist (CRNA). Previously, you paid 25% of the Plan allowance, plus any difference between our allowance and the billed amount. [See Section 5(b).]
- Your copayment for inpatient care at Preferred hospitals is now $200 per admission. Previously, you paid $100 per admission. [See Sections 5(c) and 5(e).]
- Your copayment for ambulance transport related to a medical emergency is now $100 per day for ground ambulance transport and $150 per day for air or sea ambulance transport. Previously, you paid $50 per day for these types of services. [See Section 5(d).]

- You now pay 100% of the billed amount up to a maximum of $350 per visit for professional care provided in an emergency room by a Non-participating emergency room physician. Previously, you paid any difference between the Plan allowance and the billed amount for care related to an accidental injury, and 25% of the Plan allowance, plus any difference between our allowance and the billed amount for care related to a medical emergency. [See Section 5(d).]
- You must now obtain prior approval before receiving any outpatient Mental Health/Substance Abuse services. We no longer require a treatment plan from your provider prior to your ninth outpatient Mental Health/Substance Abuse visit. (See pages 16 and 84.)

Changes to our Basic Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 134.)
- Your copayment for office visits to Preferred primary care professionals is now $25 per visit. Previously, you paid $20 per visit. [See Sections 5(a), 5(d), and 5(e).]
- Your copayment for outpatient facility care at Preferred hospitals is now $50 per day per facility. Previously, you paid $40 per day. [See Sections 5(c) and 5(e).]
- Your copayment for emergency room care related to an accidental injury or medical emergency is now $75 per visit. Previously, your copayment was $50 per visit. [See Section 5(d).]
- Your copayment for ambulance transport related to a medical emergency or accidental injury is now $100 per day for ground ambulance transport and $150 per day for air or sea ambulance transport. Previously, you paid $50 per day for these types of services. [See Section 5(d).]
- Your copayment for Level II formulary or preferred brand-name drugs purchased at a Preferred Retail Pharmacy is now $35 per prescription. In addition, the minimum amount you pay for Level III non-formulary or non-preferred brand-name drugs is now $45 for each 34-day supply, or $135 for a 90-day supply. Previously, you paid $30 for Level II prescriptions, and for Level III prescriptions, you paid a minimum of $35 for each purchase of a 34-day supply, or $105 for a 90-day supply. (See page 91.)

Changes to both our Standard and Basic Options

- We now provide benefits for set-up of portable X-ray equipment. Previously, benefits were not available for this service. (See page 31.)
- We now provide Preventive Care Benefits (Adult) for screening and behavioral change interventions for tobacco use and alcohol/substance abuse. Previously, Preventive Care Benefits were not available for these services. (See page 32.)
- We now provide benefits for the nonsurgical treatment of amblyopia and strabismus for children from birth through age 18. Previously, we provided benefits through age 12. (See page 42.)
- We now provide benefits for hearing aids for adults, limited to $1,000 per ear per 36-month period subject to the member cost-sharing amounts shown on page 43. Previously, benefits for adults were limited to bone anchored hearing aids.
- We now provide benefits for wigs (scalp hair prosthesis) due to hair loss due to chemotherapy for the treatment of cancer, limited to a maximum of $350 for one wig per lifetime. Previously, benefits were not available for these types of wigs. (See page 44.)
- We now provide benefits for medical foods that are administered orally and that provide the sole source (100%) of nutrition for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food. Previously, benefits were not available for these types of products. (See page 47.)
- We now provide benefits for additional types of stem cell transplants. [See Section 5(b).]
- We now provide Prescription Drug Benefits for one influenza vaccine each flu season provided by a Preferred retail pharmacy. Previously, Prescription Drug Benefits were not available for these types of vaccines. (See page 90.)
- Certain Preferred facilities have now been selected to be Blue Distinction Centers for Complex and Rare Cancers℠. More information about these centers appears on page 13.
- Chiropractors/Doctors of Chiropractic (D.C.) are now considered “other covered health care professionals.” Previously, these types of providers were listed as physicians. (See page 11.)

- You must now obtain prior approval for outpatient surgery for morbid obesity, outpatient surgical correction of congenital anomalies, and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Previously, these types of services did not require prior approval. (See page 16.)
- We clarified that benefits are not available for online medical evaluation and management services. (See page 31.)
- We clarified that we do not provide benefits for preventive medicine counseling and/or risk factor reduction intervention, interpretation of health risk assessments, or self-administered health risk assessments. (See page 32.)
- We clarified that benefits are not available for services provided by massage therapists. (See page 40.)
- We clarified that benefits are not available for orthodontic care, except for orthodontia associated with surgery to correct accidental injuries. (See page 55.)
- We clarified that benefits are not available for physician charges for shift differentials. (See page 107.)
- We clarified that benefits are not available for services performed or billed by residential therapeutic camps or for light boxes. (See pages 83 and 87.)
- We clarified the types of professional providers covered for Mental Health and Substance Abuse Care. (See pages 82 and 85.)
- We clarified that we may request medical records to support your claim for services received overseas. (See page 104.)
- We clarified that World Access Service Corporation is now Mondial Assistance. (See page 104.)

Section 3. How you receive benefits

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail or internet pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP Enrollment Services, 840 First Street, NE, Washington, DC 20065. You may also request replacement cards through our Web site, www.fepblue.org.

Where you get covered care

Under Standard Option, you can get care from any "covered professional provider" or "covered facility provider." How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those "covered professional providers" or "covered facility providers" that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 14 for the exceptions to this requirement. Refer to page 6 for more information about Preferred providers.

For Basic Option, the term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

- **Covered professional providers**

We consider the following to be covered professionals when they perform services within the scope of their license or certification:

Physicians – Doctors of medicine (M.D.); osteopathy (D.O.); dental surgery (D.D.S.); medical dentistry (D.M.D.); podiatric medicine (D.P.M.); and optometry (O.D.).

Other Covered Health Care Professionals – Professionals who provide additional covered services and meet the state's applicable licensing or certification requirements and the requirements of the Local Plan. Examples of other covered health care professionals include:

- **Audiologist –** A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Chiropractor/Doctor of Chiropractic (D.C.)** – A professional who is licensed as a chiropractor by the appropriate government agency to practice chiropractic medicine where the service is performed.
- **Clinical Psychologist–** A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker–** A social worker who (1) has a master's or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Diabetic Educator–** A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.

- **Dietician –** A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Independent Laboratory–** A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Nurse Midwife –** A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.
- **Nurse Practitioner/Clinical Specialist –** A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.
- **Nursing School Administered Clinic –** A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting – primarily in rural or inner-city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient "office" services rather than facility charges.
- **Nutritionist –** A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Physical, Speech, and Occupational Therapist –** A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.
- **Physician Assistant –** A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.
- **Otherprofessional providers** specifically shown in the benefit descriptions in Section 5.

Medically underserved areas. In the states OPM determines are "medically underserved":

Under Standard Option, we cover any licensed medical practitioner for any covered service performed within the scope of that license.

Under Basic Option, we cover any licensed medical practitioner who is **Preferred** for any covered service performed within the scope of that license.

For 2009, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, and Wyoming.

- **Covered facility providers**

Covered facilities include those listed below, when they meet the state's applicable licensing or certification requirements.

- **Hospital -** An institution, or a distinct portion of an institution, that:

1. Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
2. Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
3. Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

- **Freestanding Ambulatory Facility–** A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:

1. Provides services in an outpatient setting;
2. Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
3. Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
4. Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

- **Blue Distinction Centers for Bariatric Surgery, Cardiac Care, and Complex and Rare Cancers**

Certain Preferred facilities have been selected to be Blue Distinction Centers for Bariatric Surgery, Cardiac Care, and/or Complex and Rare Cancers. These facilities meet stringent quality criteria established by expert physician panels, surgeons, and other medical professionals. The Blue Distinction Centers for Bariatric Surgery℠ provide a full range of bariatric surgical care services, including inpatient care, post-operative care, follow-up care, and patient education. The Blue Distinction Centers for Cardiac Care℠ provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization (including percutaneous coronary interventions), and cardiac surgery (including coronary artery bypass graft surgery). The Blue Distinction Centers for Complex and Rare Cancers℠ offer comprehensive inpatient cancer care programs for adults, delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise in treating complex and rare types of cancer.

If you are considering covered bariatric surgery, cardiac procedures, or inpatient treatment for a complex or rare cancer, you may want to consider receiving those services at a Blue Distinction Center. You can find these facilities listed in the online provider directory available at www.fepblue.org, or by calling the customer service number listed on the back of your ID card.

- **Blue Distinction Centers for Transplants℠**

In addition to Preferred transplant facilities, you have access to the Blue Distinction Centers for Transplants℠, a centers of excellence program. Blue Distinction Centers for Transplants are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. These facilities negotiate a payment for transplant services performed during the transplant period (see page 125 for the definition of "transplant period").

Members who choose to use a Blue Distinction Centers for Transplants facility for a covered transplant only pay the $200 per admission copayment under Standard Option, or the $100 per day copayment ($500 maximum) under Basic Option, for the transplant period. Members are not responsible for additional costs for included professional services. Regular Preferred benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period.

Blue Distinction Centers for Transplants are available for eight types of transplants: heart; heart-lung; single, double, or lobar lung; liver; pancreas; simultaneous pancreas-kidney; simultaneous liver-kidney; and autologous or allogeneic bone marrow (see page 63 for limitations).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payer) must contact us at the customer service number listed on the back of their ID card before obtaining services. We will refer you to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants and assistance in arranging for your transplant at a Blue Distinction Centers for Transplants facility.

- **Cancer Research Facility –** A facility that is:

1. A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;
2. An NCI-designated Cancer Center; or
3. An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

- **Other facilities** specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

Under Standard Option, you can go you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

1. Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
2. Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
3. Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
4. Services of assistant surgeons;
5. Special provider access situations (contact your Local Plan for more information); or
6. Care received outside the United States and Puerto Rico.

Unless otherwise noted in Section 5, when services of Non-preferred providers are covered in a special exception, benefits will be provided based on the Plan allowance. You are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for:

- **Your hospital stay**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

- You, your representative, your doctor, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission.
- If you have an **emergency admission** due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, your doctor, or your hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, proposed treatment, or surgery;
  - Name and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.

How to precertify an admission

- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your hospital stay needs to be extended:**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor, or the hospital must ask us to approve the additional days.

- **What happens when you do not follow the precertification rules**

- If no one contacts us, we will decide whether the hospital stay was medically necessary.
- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty. [See Section 5(c) for payment information.]
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits or inpatient physician care benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and you did not get the additional days precertified, then:

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.

- **Exceptions:**

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay. (See page 13 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payer for the hospital stay. (See page 13 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

- **Other services**

These services require prior approval under both Standard and Basic Option:

- **Outpatient surgical services –** The surgical services listed below require prior approval when they are to be performed on an outpatient basis. This requirement applies to both the physician services and the facility services from Preferred, Participating/Member, and Non-participating/Non-member providers. You must contact us at the customer service number listed on the back of your ID card before obtaining these types of services.
- Outpatient surgery for morbid obesity;
- Outpatient surgical correction of congenital anomalies; and

- Outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth.
- **Home hospice care –** Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved. See page 73 for information about the exception to this requirement.
- **Outpatient mental health and substance abuse treatment – You must call us** at the mental health and substance abuse number listed on the back of your ID card **before receiving any outpatient professional or outpatient facility care from Preferred providers.** We will then provide you with the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving. For intensive outpatient treatment and partial hospitalization from Preferred providers, we will request the medical evidence we need to make our coverage determination. We will also consider the necessary duration of either of these services.
- **Organ/tissue transplants –** Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
- **Clinical trials for certain organ/tissue transplants –** See pages 60 and 61 for the list of conditions covered only in clinical trials for blood or marrow stem cell transplants. Contact our Transplant Clinical Trials Information Unit at 1-800-225-2268 for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

Note: For the purposes of the blood or marrow stem cell clinical trial transplants listed on pages 60 and 61, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board of the Cancer Research Facility (see page 13) where the procedure is to be delivered.

- **Prescription drugs –** Certain prescription drugs require prior approval. Contact our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 94 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

Note: Benefits for drugs to aid smoking cessation that require a prescription by Federal law are limited to one course of treatment per calendar year. Prior approval is required before benefits will be provided for additional medication. To obtain approval, the physician must certify the patient is participating in a smoking cessation program that provides clinical treatment, including counseling and behavioral therapies.

Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through an internet pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

Under Standard Option, members may use our Mail Service Prescription Drug Program to fill their prescriptions. However, the Mail Service Prescription Drug Program also will not fill your prescription until you have obtained prior approval. Medco, the administrator of the Mail Service Prescription Drug Program, will hold your prescription for you up to thirty days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Surgery by Non-participating providers under Standard Option

You may receive specific benefit information in advance about non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 16 or is one of the transplant procedures listed above) – even if the charge will be $5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of $20 for the office visit and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of $200 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

Under Standard Option, the calendar year deductible is $300 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach $600.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible ($220) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Under Basic Option, there is **no calendar year deductible**.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only,** coinsurance does not begin until you meet your deductible.

Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your $300 calendar year deductible.

If your provider routinely waives your cost

Note: **If your provider routinely waives** (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges $100 for a service but routinely waives your 30% Standard Option coinsurance, the actual charge is $70. We will pay $49.00 (70% of the actual charge of $70).

Waivers

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service number on the back of your ID card.

Differences between our allowance and the bill

Our **"Plan allowance"** is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. In this Plan, we have the following types of providers:

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

  Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your Preferred physician will not bill you for the $50 difference between our allowance and his/her bill.

  Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges $150 for covered services subject to a $25 copayment. Even though our allowance may be $100, you still pay just the $25 copayment. Because of the agreement, your Preferred physician will not bill you for the $125 difference between your copayment and his/her bill.

  Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

  Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $150, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 30% of our $100 allowance ($30). Because of the agreement, your Participating physician will not bill you for the $50 difference between our allowance and his/her bill.

  Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 14 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you.

Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance –**plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see page 124). For example, you see a Non-participating physician who charges $150. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 30% of the $100 Plan allowance or $30. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 14 for the exceptions to this requirement.

The following table illustrates examples of how much you have to pay out-of-pocket for services from a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges $150 and the Plan allowance is $100. For Standard Option, the table shows the amount you pay if you have met your calendar year deductible.

Example	Preferred Physician Standard Option	Preferred Physician Basic Option	Participating physician (Standard Option*)	Non-participating physician (Standard Option*)
Physician's charge	$150	$150	$150	$150
Our allowance	We set it at: $100	We set it at: $100	We set it at: $100	We set it at: $100
We pay	85% of our allowance: $85	Our allowance less copay: $75	70% of our allowance: $70	70% of our allowance: $70
You owe: Coinsurance	15% of our allowance: $15	Not applicable	30% of our allowance: $30	30% of our allowance: $30
You owe: Copayment	Not applicable	$25	Not applicable	Not applicable
+Difference up to charge?	No: $0	No: $0	No: $0	Yes: $50
TOTAL YOU PAY	$15	$25	$30	$80

***Under Basic Option, there are no benefits for care performed by Participating and Non-participating physicians. You must use Preferred providers in order to receive benefits.** See page 14 for the exceptions to this requirement.

Note: Under Standard Option, had you not met any of your deductible in the above examples, only our allowance ($100), which you would pay in full, would count toward your deductible.

Important notice!

Preferred hospitals may contract with Non-participating providers to provide certain medical or surgical services at their facilities. Non-participating providers have no agreements with your Local Plan to limit what they can bill you. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.

Here is an example: You have coverage under Standard Option and go into a Preferred hospital for surgery. During surgery, you receive the services of a Non-participating anesthesiologist. Under Standard Option, members pay the amount billed for services provided in Preferred facilities by Non-participating anesthesiologists, up to a maximum copayment amount of $800 per anesthetist per day (no deductible or coinsurance amounts apply). For Preferred provider services, members pay only a coinsurance amount of 15% of the Preferred provider allowance after meeting the $300 calendar year deductible.

In this example, the Non-participating anesthesiologist charges $1,200 for his/her services. Our Preferred provider allowance for those services is $400. For the Non-preferred anesthesiologist's services, you would be responsible for paying the full $800 copayment amount. If you instead received services from a Preferred anesthesiologist, you would pay only 15% of the $400 allowance (after meeting your deductible), or $60, resulting in a savings to you of $740 ($800 - $60 = $740).

Always request Preferred providers for your care. Call your Local Plan at the number listed on the back of your ID card or go to our Web site, www.fepblue.org, to check the contracting status of your provider or to locate a Preferred provider near you.

- **Overseas providers.** We pay overseas claims at Preferred benefit levels, using an Overseas Fee Schedule as our Plan allowance. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance (and, under Standard Option, any deductible amount that may apply). See Section 5(i) for more information about our overseas benefits.
- **Dental care. Under Standard Option,** we pay scheduled amounts for routine dental services and you pay any balance. **Under Basic Option,** you pay $20 for any covered evaluation and we pay the balance for covered services. See Section 5(g) for a listing of covered dental services and additional payment information.
- **Hospital care.** You pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option,** you must meet your deductible before we begin providing benefits for certain hospital-billed services. **Under Basic Option,** you must use **Preferred** facilities in order to receive benefits. See page 14 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

If the total amount of out-of-pocket expenses in a calendar year for you and your covered family members for deductibles (Standard Option only), coinsurance, and copayments (other than those listed below) exceeds $7,000 under Standard Option, or $5,000 under Basic Option, then you and any covered family members will not have to continue paying them for the remainder of the calendar year.

Standard Option Preferred maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds $5,000 in a calendar year under Standard Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year when you continue to use Preferred providers. You will, however, have to pay them when you use Non-preferred providers, until your out-of-pocket expenses (for the services of both Preferred and Non-preferred providers) reach $7,000 under Standard Option, as shown above.

Basic Option maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds $5,000 in a calendar year under Basic Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See pages 19-21;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your 30% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 30% coinsurance for outpatient care by a Non-member facility;
- Under Standard Option, your $800 copayment (or the total amount you paid if less than $800) for anesthesia provided by a Non-participating anesthesiologist or certified registered nurse anesthetist (CRNA). See Section 5(b);
- Under Standard Option, your $350 per visit copayment (or the total amount you paid if less than $350) for professional care provided in an emergency room by a Non-participating emergency room physician. See Section 5(d);
- Your expenses for mental conditions and substance abuse care by a Non-preferred professional or facility provider;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- The $500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- Under Basic Option, coinsurance you pay for non-formulary brand-name drugs; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 14 for the exceptions to the requirement to use Preferred providers.

Carryover

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 21 and on this page until the effective date of your new plan.

- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on page 21 and on this page) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you . . .

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount – the "equivalent Medicare amount" – set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your deductible (Standard Option only), coinsurance, or copayments under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the equivalent Medicare amount.

And, for your physician care, the law requires us to base our payment and your applicable coinsurance or copayment on . . .

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician . . .	Then you are responsible for . . .
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	Standard Option: your deductibles, coinsurance, and copayments Basic Option: your copayments and coinsurance
Participates with Medicare or accepts Medicare assignment and is **not** in our Preferred network	Standard Option: your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount Basic Option: all charges
Does not participate with Medicare, and is in our Preferred network	Standard Option: your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount Basic Option: your copayments and coinsurance, and any balance up to 115% of the Medicare approved amount
Does not participate with Medicare and is **not** in our Preferred network	Standard Option: your deductibles, coinsurance, copayments, Basic Option: all charges

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the MRA statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment (see note below for Basic Option).

Note: **Under Basic Option,** you must see **Preferred** providers in order to receive benefits. See page 14 for the exceptions to this requirement.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 5. Benefits

See pages 9 and 10 for how our benefits changed this year. Page 132 and page 133 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Standard and Basic Option Overview

This Plan offers both a Standard and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and Basic Option Section 5 is divided into subsections. Please read *Important things youshould keep in mind* at the beginning of the subsections. Also read the *General exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or at our Web site at www.fepblue.org.

Each option offers unique features.

- **Standard Option** When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a $20 copayment for office visits. Standard Option also features both a Preferred retail and a Preferred mail service prescription drug program.

- **Basic Option** Basic Option does not have a calendar year deductible. Most services are subject to copayments ($25 for primary care providers and $30 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred retail pharmacy program.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Standard Option,** we provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, pathologists, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See below and page 14 for the exceptions to this requirement.**
- **Under Basic Option,** we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers (under Basic Option) and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services	**Standard Option**	**Basic Option**
Professional services of physicians and other health care professionals: • Outpatient consultations • Outpatient second surgical opinions • Office visits • Home visits • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(f) for prescription drug coverage] • Neurological testing ***Note:*** Please refer to page 31 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a physician, and to page 69 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.	Preferred: $20 copayment for the office visit charge (No deductible) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Inpatient professional services: • During a hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits ***Note:*** A consulting physician employed by the hospital is not the attending physician. • Consultations when requested by the attending physician • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(c) for our coverage of drugs you receive while in the hospital] • Neurological testing • Second surgical opinion	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	**Standard Option**	**Basic Option**
• Nutritional counseling when billed by a covered provider	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
Not covered : • *Routine services except for those Preventive care services described on pages 32-34* • *Online medical evaluation and management services* • *Inpatient private duty nursing* • *Standby physicians* • *Routine radiological and staff consultations required by hospital rules and regulations* • *Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)]* ***Note:*** *If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**Standard Option**	**Basic Option**
Diagnostic tests provided, or ordered and billed by a physician, such as: • Blood tests • Bone density tests – screening or diagnostic • CT scans/MRIs • EKGs and EEGs • Genetic testing – diagnostic • Laboratory tests • Pathology services • Ultrasounds • Urinalysis • X-rays (including set-up of portable X-ray equipment) Diagnostic services billed by an independent laboratory	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and other diagnostic tests (cont.)	**Standard Option**	**Basic Option**
Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Preventive care, adult	**Standard Option**	**Basic Option**
Home and office visits for routine (screening) physical examinations **Under Standard Option,** benefits are limited to the following services when performed as part of a routine physical examination: • History and risk assessment • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) when performed by a Preferred provider or any independent laboratory • Screening and behavioral change interventions for tobacco use and alcohol/substance abuse ***Note:*** The benefits listed above do not apply to children up to age 22. (See benefits under *Preventive care, children*, this section.) • Chlamydial infection test **Under Basic Option,** benefits are provided for all of the services listed above and for other appropriate screening tests and services.	Preferred: $20 copayment for the examination (No deductible); nothing for services or tests ***Note:*** We provide benefits for adult routine physical examinations only when you receive these services from a **Preferred provider**. Participating: You pay all charges Non-participating: You pay all charges ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.
Not covered:	*All charges*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**Standard Option**	**Basic Option**
• *Preventive medicine counseling and/or risk factor reduction intervention, except as stated above for tobacco use and alcohol/substance abuse* • *Interpretation of health risk assessments* • *Self-administered health risk assessments*	*All charges*	*All charges*
Cancer diagnostic tests and screening procedures • Colorectal cancer tests, including: - Fecal occult blood test - Colonoscopy (see page 52 for our payment levels for diagnostic colonoscopies billed for by a physician) - Sigmoidoscopy - Double contrast barium enema • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer tests (including Pap tests) • Breast cancer tests (mammograms) Other diagnostic and screening procedures • Ultrasound for aortic abdominal aneurysm ***Note:*** Benefits are not available for genetic testing related to family history of cancer or other disease.	Preferred: $20 copayment for associated office visits (No deductible); nothing for services or tests ***Note:*** We provide benefits in full for preventive (screening) tests and immunizations only when you receive these services from a **Preferred provider** on an outpatient basis. If these services are billed separately from the routine physical examination, you may be responsible for paying an additional copayment for each office visit billed. Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.
Routine immunizations (as licensed by the U.S. Food and Drug Administration), limited to: • Hepatitis immunizations (Types A and B) for patients with increased risk or family history • Herpes Zoster (shingles) vaccines • Human Papillomavirus (HPV) vaccines • Influenza (one each flu season) and pneumococcal vaccines ***Note:*** See page 90 for our coverage of influenza (flu) vaccines provided by Preferred retail pharmacies. • Meningococcal vaccines	Preferred: $20 copayment for associated office visits (No deductible); nothing for immunizations Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment for associated office visits; nothing for immunizations Preferred specialist: $30 copayment for associated office visits; nothing for immunizations Participating/Non-participating: You pay all charges

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**Standard Option**	**Basic Option**
• Tetanus-diphtheria (Td) booster – once every 10 years	Preferred: $20 copayment for associated office visits (No deductible); nothing for immunizations Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment for associated office visits; nothing for immunizations Preferred specialist: $30 copayment for associated office visits; nothing for immunizations Participating/Non-participating: You pay all charges ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.
Not covered: Office visit charges associated with preventive services and routine immunizations performed by Participating and Non-participating providers	*All charges*	*All charges*
Preventive care, children	**Standard Option**	**Basic Option**
We provide benefits for the following services: • All healthy newborn visits including routine screening (inpatient or outpatient) • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling, or adopted from outside the United States: - Routine physical examinations - Routine hearing tests - Laboratory tests - Immunizations - Human Papillomavirus (HPV) vaccines - Meningococcal vaccine - Rotavirus vaccines - Related office visits	Preferred: Nothing (No deductible) Participating: Nothing (No deductible) Non-participating: Nothing (No deductible) up to the Plan allowance. You are responsible only for any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.

Benefit Description	You Pay	
Maternity care	**Standard Option**	**Basic Option**
Complete maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided, or ordered and billed by a physician or nurse midwife, such as: • Prenatal care (including ultrasound, laboratory, and diagnostic tests) • Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) ***Note:*** Benefits are not provided for oral tocolytic agents. Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations described on page 47. • Delivery • Postpartum care • Assistant surgeons/surgical assistance if required because of the complexity of the delivery • Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant	Preferred: Nothing (No deductible) ***Note:***For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers. Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance for the delivery itself and any other maternity related surgical procedures to be provided by a Non-participating physician when the charge for that care will be **$5,000 or more**. Call your Local Plan at the customer service number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services. ***Note:***For anesthesia provided by a Non-participating anesthetist, you pay 100% of the billed amount up to a maximum of $800 per anesthetist per day (no deductible).	Preferred: Nothing ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to $100 per admission. For outpatient facility services related to maternity, see pages 69-71. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 15 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary.		

Maternity care - continued on next page

Benefit Description	You Pay	
Maternity care (cont.)	**Standard Option**	**Basic Option**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. ***Note:*** When a newborn requires definitive treatment including incubation charges by reason of prematurity or evaluation for medical or surgical reasons during or after the mother's confinement, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits. ***Note:*** See page 52 for our payment levels for circumcision.		
Not covered: • *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest* • *Genetic testing of the baby's father*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services, limited to: • Depo-Provera • Diaphragms and contraceptive rings • Intrauterine devices (IUDs) • Implantable contraceptives • Oral and transdermal contraceptives • Voluntary sterilization [see *Surgical procedures* in Section 5(b)] ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay $100 for related surgical procedures. See Section 5(b) for our coverage for related surgical procedures. ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: • *Reversal of voluntary surgical sterilization* • *Contraceptive devices not describe*	*All charges*	*All charges*

Benefit Description	You Pay	
Infertility services	**Standard Option**	**Basic Option**
Diagnosis and treatment of infertility, except as shown in *Not covered* ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Not covered : • *Assisted reproductive technology (ART) procedures, such as:* - *artificial insemination (AI)* - *in vitro fertilization (IVF)* - *embryo transfer and Gamete Intrafallopian Transfer (GIFT)* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures, such as sperm banking*	*All charges*	*All charges*
Allergy care	**Standard Option**	**Basic Option**
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit; nothing for injections Preferred specialist: $30 copayment per visit; nothing for injections Participating/Non-participating: You pay all charges (except as noted below)

Allergy care - continued on next page

Benefit Description	You Pay	
Allergy care (cont.)	**Standard Option**	**Basic Option**
		Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Not covered: Provocative food testingand sublingual allergy desensitization	*All charges*	*All charges*
Treatment therapies	**Standard Option**	**Basic Option**
Outpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *How to get approval for . . .* in Section 3 (page 17). • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy ***Note:*** Home nursing visits associated with Home IV/infusion therapy are covered as shown under Home health services on page 47. • Outpatient cardiac rehabilitation ***Note:*** See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Inpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *How to get approval for . . .* in Section 3 (page 17). • Renal dialysis – Hemodialysis and peritoneal dialysis • Pharmacotherapy [see Section 5(c) for our coverage of drugs administered in connection with these treatment therapies]	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Benefit Description	You Pay	
Physical therapy, occupational therapy, speech therapy, and cognitive therapy	**Standard Option**	**Basic Option**
• Physical therapy, occupational therapy, and speech therapy when performed by a licensed therapist or physician • Cognitive rehabilitation therapy when performed by a licensed therapist or physician ***Note:*** When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the facility.	Preferred: $20 copayment per visit (No deductible) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. ***Note:*** Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. Participating/Non-participating: You pay all charges ***Note:*** See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.
Not covered: • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Maintenance or palliative rehabilitative therapy* • *Exercise programs* • *Hippotherapy (exercise on horseback)* • *Services provided by massage therapists*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**Standard Option**	**Basic Option**
Hearing tests related to illness or injury	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies.

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies) (cont.)	**Standard Option**	**Basic Option**
		Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated under Preventive care, children)* • *Hearing aids (except as described on page 43)* • *Testing and examinations for the prescribing or fitting of hearing aids(except as needed for covered hearing aids described on page 43)*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard Option**	**Basic Option**
Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed: • To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; • In lieu of surgery when the condition can be corrected by surgery, but surgery is precluded because of age or medical condition ***Note:*** Benefits are provided for refractions only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described above.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 ***Note:*** See Section 5(b), *Surgical procedures*, for coverage for surgical treatment of amblyopia and strabismus.	Preferred: $20 copayment (No deductible) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: • *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 41* • *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above*	*All charges*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Vision services (testing, treatment, and supplies) (cont.)	**Standard Option**	**Basic Option**
• *LASIK, INTACS, radial keratotomy, and other refractive services except as described on page 41*	*All charges*	*All charges*
Foot care	**Standard Option**	**Basic Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes ***Note:*** See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts. ***Note:*** See Section 5(b) for our coverage for surgical procedures.	Preferred: $20 copayment for the office visit (No deductible); 15% of the Plan allowance for all other services (deductible applies) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above	*All charges*	*All charges*
Orthopedic and prosthetic devices	**Standard Option**	**Basic Option**
Orthopedic braces and prosthetic appliances such as: • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements • Hearing aids for children up to age 22, limited to $1,000 per ear per calendar year • Hearing aids for adults age 22 and over, limited to $1,000 per ear per 36-month period ***Note:***See below for our coverage of bone anchored hearing aids. • Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to $1,000 per ear per calendar year***Note:*** Benefits for hearing aids are subject to the cost-sharing amounts shown to the right under the "You Pay" columns.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**Standard Option**	**Basic Option**
• Surgically implanted penile prostheses to treat erectile dysfunction ***Note:*** A **prosthetic appliance** is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
• Wigs (scalp hair prosthesis) due to hair loss due to chemotherapy for the treatment of cancer ***Note:*** Benefits for wigs are paid at 100% of the billed amount, limited to $350 for one wig per lifetime.	Any amount over $350 for one wig per lifetime (No deductible)	Any amount over $350 for one wig per lifetime
Not covered: • *Shoes and over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to chemotherapy for the treatment of cancer, as stated above*	*All charges*	*All charges*
Durable medical equipment (DME)	**Standard Option**	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• Walkers • Continuous passive motion (CPM) and dynamic orthotic cranioplasty (DOC) devices • Other items that we determine to be DME, such as compression stockings ***Note:*** We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers. ***Note:*** See Section 5(c) for our coverage of DME provided and billed by a facility.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered : • *Exercise and bathroom equipment* • *Lifts, such as seat, chair, or van lifts* • *Car seats* • *Air conditioners, humidifiers, dehumidifiers, and purifiers* • *Breast pumps* • *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*
Medical supplies	**Standard Option**	**Basic Option**
• Medical foods for children with inborn errors of amino acid metabolism • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally and that provide the sole source (100%) of nutrition, for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate) ***Note:*** See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies • Oxygen • Blood and blood plasma, except when donated or replaced, and blood plasma expanders	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Medical supplies - continued on next page

Benefit Description	You Pay	
Medical supplies (cont.)	**Standard Option**	**Basic Option**
Note: We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: Infant formulas used as a substitute for breastfeeding	*All charges*	*All charges*
Home health services	**Standard Option**	**Basic Option**
Home nursing care for two (2) hours per day, up to 25 visits per calendar year, when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.	Preferred: $25 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter* • *Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home,* ***except*** *as included in the benefits described on page 72*	*All charges*	*All charges*
Chiropractic	**Standard Option**	**Basic Option**
• One office visit per calendar year • One set of X-rays per calendar year • Spinal manipulations ***Note:*** Benefits may be available for other covered services you receive from chiropractors in medically underserved areas. See page 12 for additional information.	Preferred: $20 copayment per visit (No deductible) Participating: 30% of the Plan allowance	Preferred: $25 copayment per visit ***Note:*** Benefits are limited to 20 manipulations per calendar year. Participating/Non-participating: You pay all charges

Chiropractic - continued on next page

Benefit Description	You Pay	
Chiropractic (cont.)	**Standard Option**	**Basic Option**
	Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 12 manipulations per calendar year. ***Note:*** Office visits, X-rays, and spinal manipulations that you pay for while meeting your calendar year deductible count toward the appropriate benefit limit.	
Alternative treatments	**Standard Option**	**Basic Option**
Acupuncture ***Note:*** See page 64 for our coverage of acupuncture when provided as anesthesia for covered surgery. ***Note:*** See page 35 for our coverage of acupuncture when provided as anesthesia for covered maternity care. ***Note:*** We may also cover services of certain alternative treatment providers in medically underserved areas. See page 12 for additional information.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Acupuncture must be performed and billed by a physician or licensed acupuncturist. ***Note:*** Benefits for acupuncture are limited to 24 visits per calendar year. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care physician: $25 copayment per visit Preferred physician specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. ***Note:*** Acupuncture must be performed and billed by a physician. Participating/Non-participating: You pay all charges
Not covered: • *Services you receive from noncovered providers such as:* - *naturopaths* - *hypnotherapists* • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*

Benefit Description	You Pay	
Educational classes and programs	**Standard Option**	**Basic Option**
• Smoking cessation ***Note:*** See Section 5(e) for our coverage of individual and group psychotherapy for smoking cessation and Section 5(f) for our coverage of smoking cessation drugs.	Preferred: $20 copayment for the office visit charge (No deductible); 15% of the Plan allowance for all other services (deductible applies) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
• Diabetic education when billed by a covered provider ***Note:*** We cover diabetic educators, dieticians, and nutritionists who bill independently only as part of a covered diabetic education program. • Nutritional counseling for up to 4 visits per year when billed by a covered provider ***Note:*** Nutritional counseling for the treatment of anorexia and bulimia is not subject to the 4-visit limitation. ***Note:***We cover dieticians and nutritionists who bill independently for nutritional counseling.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Nutritional counseling visits (for other than anorexia and bulimia) that you pay for while meeting your calendar year deductible count toward the 4-visit limit.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation, headache, eating disorder (except as described above), and other educational clinics* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Services performed or billed by a school or halfway house or a member of its staff*	*All charges*	*All charges*

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $300 per person ($600 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We say "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Standard Option,** we provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, pathologists, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See below and page 14 for the exceptions to this requirement.**
- **Under Basic Option,** we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 16 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants);** and if your surgical procedure requires an inpatient admission, **YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- Standard Option members may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be $5,000 or more. See page 17 for more information.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no deductible under Basic Option.		
Surgical procedures	**Standard Option**	**Basic Option**
A comprehensive range of services provided, or ordered and billed by a physician, such as: • Operative procedures • Treatment of fractures and dislocations, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Colonoscopy – diagnostic • Other endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery* on page 54) • Treatment of burns • Circumcision of newborn • Insertion of internal prosthetic devices. See Section 5(a) – *Orthopedic and prosthetic devices*, and Section 5(c) – *Other hospital services and supplies* – for our coverage for the device. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures • Gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures to treat morbid obesity – a condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with co-morbidities who has failed conservative treatment; eligible members must be age 18 or over. Benefits are also available for diagnostic studies and a psychological examination performed prior to the procedure to determine if the patient is a candidate for the procedure. ***Note:*** **You must get prior approval for outpatient surgery for morbid obesity.** Please refer to page 16 for more information.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**Standard Option**	**Basic Option**
Note: When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure. ***Note:*** We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). ***Note:*** When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.		
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician* • *Routine surgical treatment of conditions of the foot [see Section 5(a) – Foot care]* • *Cosmetic surgery* • *LASIK, INTACS, radial keratotomy, and other refractive surgery*	*All charges*	*All charges*
Reconstructive surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. ***Note:*** Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth. ***Note:*** **You must get prior approval for outpatient surgical correction of congenital anomalies.** Please refer to page 16 for more information. • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of the patient's breasts - treatment of any physical complications, such as lymphedemas	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**Standard Option**	**Basic Option**
Note: Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility. ***Note:*** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Surgery for placement of penile prostheses to treat erectile dysfunction	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Not covered: • *Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)* • *Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy, except as specifically shown*	*All charges*	*All charges*
Oral and maxillofacial surgery	**Standard Option**	**Basic Option**
Oral surgical procedures, limited to: • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth ***Note:*** **You must get prior approval for outpatient surgery needed to correct accidental injuries as described above.** Please refer to page 16 for more information. • Excision of exostoses of jaws and hard palate • Incision and drainage of abscesses and cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands, or ducts • Reduction of dislocations and excision of temporomandibular joints	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay	
Oral and maxillofacial surgery (cont.)	**Standard Option**	**Basic Option**
• Removal of impacted teeth ***Note:*** Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures involving dental implants or preparation of the mouth for the fitting or the continued use of dentures, except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically described above and in Section 5(g)*	*All charges*	*All charges*
Organ/tissue transplants	**Standard Option**	**Basic Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior approval procedures. ***Note:*** You must obtain prior approval (see page 17) for those transplants listed under *Prior Approval Requirements* on page 59. ***Note:*** Refer to pages 15-16 for information about precertification of inpatient care.		
Solid organ transplants are limited to: • Cornea	Preferred: 15% of the Plan allowance	Preferred: $100 copayment per performing surgeon

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• Heart • Heart-lung • Kidney • Liver • Pancreas • Simultaneous pancreas-kidney • Simultaneous liver-kidney • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Single, double, or lobar lung • For members with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about kidney and cornea transplants to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description. • Myeloablative allogeneic blood or marrow stem cell transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Chronic myelogenous leukemia - Fanconi's Anemia - Hemoglobinopathy (i.e., Sickle cell anemia, Thalassemia major) - High-risk neuroblastoma - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous blood or marrow stem cell transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
- Advanced non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Amyloidosis - High-risk neuroblastoma	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Blood or marrow stem cell transplants for: • Myeloablative allogeneic blood or marrow stem cell transplants for: - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous blood or marrow stem cell transplants for: - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Germ cell tumors	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:***If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Prior approval requirements: You must obtain prior approval (see page 17) from the Local Plan, for both the procedure and the facility, for the following transplant procedures:		

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• Blood or marrow stem cell transplant procedures ***Note:*** See pages 60 and 61 for services related to blood or marrow stem cell transplants covered under clinical trials. • Autologous pancreas islet cell transplant • Heart • Heart-lung • Intestinal transplants (small intestine with or without other organs) • Liver • Lung (single, double, or lobar) • Pancreas • Simultaneous liver-kidney • Simultaneous pancreas-kidney		
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or in a Blue Distinction Centers for Transplants facility in an approved clinical trial (1) For the following procedures, we provide benefits **only** when conducted at a Cancer Research Facility (see page 13) and only when performed as part of a clinical trial that meets the **requirements** listed on page 61: • Myeloablative allogeneic blood or marrow stem cell transplants for: - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma • Nonmyeloablative allogeneic blood or marrow stem cell transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Amyloidosis - Breast cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
- Colon cancer - Multiple myeloma - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcoma	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
• Autologous blood or marrow stem cell transplants for: - Breast cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Epithelial ovarian cancer ***Note:*** If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the **requirements** shown below is not available at a Cancer Research Facility where you are eligible, we will arrange for the transplant to be provided at a transplant facility designated by the Transplant Clinical Trials Information Unit. (2) For the following procedures we provide benefits **only** when performed in a specific NIH-sponsored, multi-center, comparative clinical trial and when the **requirements** listed below are met: • Autologous blood or marrow stem cell transplants for the following autoimmune diseases: - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis (3) **Requirements** for blood or marrow stem cell transplants covered under clinical trials: For these blood or marrow stem cell transplant procedures and related services or supplies covered only through clinical trials: • You must contact our Transplant Clinical Trials Information Unit at 1-800-225-2268 for prior approval (see page 17);	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered; and • The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous blood or marrow stem cell transplant • Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions listed on pages 57, 58, or 61 ***Note:*** Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long term storage of stem cells. • Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions listed on pages 57, 58, 60, or 61 • Related medical and hospital expenses of the donor, as part of a covered blood or marrow stem cell transplant procedure • Related services or supplies provided to the recipient ***Note:*** See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/Tissue Transplants at Blue Distinction Centers for Transplants

We participate in the Blue Distinction Centers for Transplants℠ program, a centers of excellence program for the organ/tissue transplants listed below. You will receive enhanced benefits if you use a Blue Distinction Centers for Transplants facility.

All members (including those who have Medicare Part A or another group health insurance policy as their primary payer) must contact us at the customer service number listed on the back of their ID card before obtaining services. You will be referred to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants.

- Heart
- Heart-lung
- Liver
- Pancreas
- Simultaneous liver-kidney
- Simultaneous pancreas-kidney
- Single or double (bilateral) lung
- Lobar transplant (living donor lung)
- Blood or marrow stem cell transplants listed on pages 57, 58, 60, and 61
- Related transplant services listed on page 62

Note: Benefits for cornea, kidney-only, and intestinal transplants are not available through Blue Distinction Centers for Transplants. See page 56 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: Members will not be responsible for separate cost-sharing for the included professional services (see page 13).

Note: See pages 57-61 for requirements related to blood or marrow stem cell transplant coverage.

Note: See page 13 for special instructions regarding all admissions to Blue Distinction Centers for Transplants.

Organ/tissue transplants	Standard Option	Basic Option
Not covered: • *Transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, except those performed for full siblings or the unrelated actual donor* • *Implants of artificial organs, including those implanted as a bridge to transplant and/or as destination therapy*	*All charges*	*All charges*

Anesthesia	Standard Option	Basic Option
Anesthesia (including acupuncture) for covered medical or surgical services when requested by the attending physician and performed by: • a certified registered nurse anesthetist (CRNA), or • a physician other than the physician (or the assistant) performing the covered medical or surgical procedure Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness. ***Note:*** See Section 5(c) for our payment levels for anesthesia services billed by a facility.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 100% of the billed amount up to a maximum of $800 per anesthetist per day (No deductible)	Preferred: Nothing Participating/Non-participating: You pay all charges

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section, unlike Sections 5(a) and 5(b), the **Standard Option** calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is $300 per person ($600 per family) under Standard Option.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 16 for more information.**
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your inpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.		
Inpatient hospital	**Standard Option**	**Basic Option**
Room and board, such as: • semiprivate or intensive care accommodations • general nursing care • meals and special diets	Preferred: $200 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days	Preferred: $100 per day copayment up to $500 per admission for unlimited days Member/Non-member: You pay all charges

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
Note: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see page 123 for more information.	Preferred: $200 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment ***Note:*** If you are admitted to a Non-member facility due to a **medical emergency or accidental injury**, you pay a $300 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred: $100 per day copayment up to $500 per admission for unlimited days Member/Non-member: You pay all charges
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic laboratory tests, pathology services, MRIs, machine diagnostic tests, and X-rays • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling • Acute inpatient rehabilitation ***Note:*** Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 15 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days.	Preferred: $200 per admission copayment for unlimited days ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission for unlimited days ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered services is limited to $100 per admission. Member/Non-member: You pay all charges

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
• We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g). ***Note:*** See pages 35-36 for other covered maternity services. ***Note:*** See page 47 for coverage of blood and blood products.	Preferred: $200 per admission copayment for unlimited days ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission for unlimited days ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered services is limited to $100 per admission. Member/Non-member: You pay all charges
Not covered: *Hospital room and board expenses when, in our judgement, a hospital admission or portion of an admission is:* • *Custodial or long term care* • *Convalescent care or a rest cure* • *Domiciliary care provided because care in the home is not available or is unsuitable* • *Not medically necessary, such as when services did not require the acute/subacute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:* - *Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)* - *Admissions primarily for diagnostic studies, laboratory and pathology services, X-rays, MRIs, or machine diagnostic teststhat could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
Note: *If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered servicesor supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.* • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Inpatient private duty nursing*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**	**Basic Option**
Outpatient **medical services** performed and billed by a hospital or freestanding ambulatory facility, such as: • Use of special treatment rooms • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Chemotherapy and radiation therapy • Intravenous (IV)/infusion therapy • Cardiac rehabilitation • Pulmonary rehabilitation • Physical, occupational, and speech therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency medical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen ***Note:*** See pages 76-80 for our payment levels for care related to a medical emergency or accidental injury.	Preferred facilities: 15% of the Plan allowance (calendar year deductible applies) ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility. Member facilities: 30% of the Plan allowance (calendar year deductible applies) Non-member facilities: 30% of the Plan allowance (calendar year deductible applies) ***Note:*** See pages 32-34 for our payment levels for covered preventive care services for adults and children. ***Note:*** See page 40 for our coverage of physical, occupational, and speech therapy.	Preferred: $50 copayment per day per facility (except for diagnostic tests as noted below) Member/Non-member: You pay all charges (except for diagnostic tests as noted below) ***Note:*** For outpatient diagnostic tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility. ***Note:*** See page 34 for our payment levels for routine adult immunizations and preventive care services for children.
Outpatient **surgery and related services** performed and billed for by a hospital or freestanding ambulatory facility, such as: • Operating, recovery, and other treatment rooms	Preferred facilities: 15% of the Plan allowance	Preferred: $50 copayment per day per facility (except for diagnostic tests as noted below)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Basic Option**
• Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Facility supplies for hemophilia home care • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Visits to the outpatient department of a hospital for non-emergency surgical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen ***Note:*** See page 71 for outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility. ***Note:*** See pages 76-80 for our payment levels for care related to a medical emergency or accidental injury. ***Note:*** We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries. We cover outpatient care related to other types of dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), *Dental benefits*, for additional benefit information. ***Note:*** See pages 35-36 for other covered maternity services.	Preferred facilities: 15% of the Plan allowance ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount and pay for covered services in full when you use a Preferred facility. Member facilities: 30% of the Plan allowance Non-member facilities: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $50 copayment per day per facility (except for diagnostic tests as noted below) Member/Non-member: You pay all charges (except for diagnostic tests as noted below) ***Note:***F or outpatient diagnostic tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:***Benefits for screening colonoscopies are subject to the cost-sharing amounts shown above. ***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility.
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a hospital or freestanding ambulatory facility, such as: • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment	Preferred facilities: 15% of the Plan allowance (calendar year deductible applies) ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility.	Preferred: 30% of the Plan allowance ***Note:*** You may also be responsible for paying a $50 copayment per day per facility for outpatient services. Member/Non-member: You pay all charges

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Basic Option**
	Member facilities: 30% of the Plan allowance (calendar year deductible applies) Non-member facilities: 30% of the Plan allowance, plus any difference between our allowance and the billed amount (calendar year deductible applies)	***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility.
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**	**Basic Option**
Limited to the following benefits for Medicare Part A copayments: When Medicare Part A is the primary payer (meaning that it pays first) and has made payment, **Standard Option** provides limited secondary benefits. We pay the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases. If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day. ***Note:*** See page 40 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note:*** **If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.**	Preferred: Nothing Participating/Member: Nothing Non-participating/Non-member: Nothing ***Note:*** You pay all charges not paid by Medicare after the 30th day.	*All charges*

Benefit Description	You Pay	
Hospice care	**Standard Option**	**Basic Option**
Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients in their homes. We provide **home hospice care** benefits for the services listed below for members with a life expectancy of six months or less **when prior approval is obtained from the Local Plan** and the home hospice agency is approved by the Local Plan. Our prior approval decision will be based upon the hospice treatment plan and clinical information provided to us. • Physician visits • Nursing care • Medical social services • Physical therapy • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)aides • Durable medical equipment rental • Prescription drugs • Medical supplies ***Note:*** We also cover pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. Prior approval is not required for these types of visits. ***Note:*** If Medicare Part A is the primary payer for your hospice care, prior approval is not required. However, our benefits will be limited to those services listed above. ***Note:*** Benefits are not available for home hospice care, e.g., care given by a home health aide, that is provided and billed for by other than the approved home hospice agency when the same type of care is already being provided by the home hospice agency.	Nothing	Nothing
Inpatient hospice for members receiving home hospice care benefits: Benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility. Each inpatient stay must be separated by at least 21 days. These covered inpatient hospice benefits are available only when inpatient services are necessary to:	Preferred: $200 per admission copayment Member: $300 per admission copayment Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission Member/Non-member: You pay all charges

Hospice care - continued on next page

Benefit Description	You Pay	
Hospice care (cont.)	**Standard Option**	**Basic Option**
• control pain and manage the patient's symptoms; or • provide an interval of relief (respite) to the family ***Note:*** **You are responsible for making sure that the home hospice care provider has received prior approval from the Local Plan** (see page 16 for instructions)**.** Please check with your Local Plan and/or your PPO directory for listings of approved agencies.	Preferred: $200 per admission copayment Member: $300 per admission copayment Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission Member/Non-member: You pay all charges
Not covered: Homemaker services	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: Nothing (No deductible) Participating/Member or Non-participating/Non-member: Nothing (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $300 per person ($600 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. [See Section 5(g) for dental care for accidental injury.]

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option does not apply. There is no calendar year deductible under Basic Option.		
Accidental injury	**Standard Option**	**Basic Option**
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** See Section 5(g) for dental benefits for accidental injuries.	Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible) ***Note:*** For professional care provided in an emergency room by a Non-participating emergency room physician, your responsibility is limited to 100% of the billed amount up to a maximum of $350 per visit (No deductible). See Section 5 (b) for our coverage of surgery and anesthesia provided by Non-participating professional providers other than the emergency room physician. ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.	Preferred emergency room: $75 copayment per visit Participating/Member emergency room: $75 copayment per visit Non-participating/Non-member emergency room: $75 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $75 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $25 copayment per visit **Preferred** specialist's office: $30 copayment per visit Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges

Accidental injury - continued on next page

Benefit Description	You pay	
Accidental injury (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Oral surgery except as shown in Section 5(b)* • *Injury to the teeth while eating* • *Emergency room physician charges for shift differentials*	*All charges*	*All charges*
Medical emergency	**Standard Option**	**Basic Option**
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted as a result of a medical emergency [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** Please refer to Section 3 for information about precertifying emergency hospital admissions.	Preferred: 15% of the Plan allowance ***Note:*** If you receive services in a Preferred physician's office, you pay a $20 copayment (No deductible) for the office visit, and 15% of the Plan allowance for all other services (deductible applies). Participating/Member: 30% of the Plan allowance Non-participating/Non-member: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** For professional care provided in an emergency room by a Non-participating emergency room physician, your responsibility is limited to 100% of the billed amount up to a maximum of $350 per visit (No deductible). See Section 5 (b) for our coverage of surgery and anesthesia provided by Non-participating professional providers other than the emergency room physician. ***Note:*** These benefit levels **do not** apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on pages 76-78 for the benefits we provide.	Preferred emergency room: $75 copayment per visit Participating/Member emergency room: $75 copayment per visit Non-participating/Non-member emergency room: $75 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $75 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $25 copayment per visit **Preferred** specialist's office: $30 copayment per visit

Medical emergency - continued on next page

Benefit Description	You pay	
Medical emergency (cont.)	**Standard Option**	**Basic Option**
		Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges
Not covered: Emergency room physician charges for shift differentials	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required. ***Note:*** See Section 5(c) for non-emergency ambulance services.	Preferred: $100 copayment per day for ground ambulance transport services (No deductible) Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services (No deductible) ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day (No deductible).	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: Nothing (No deductible) Participating/Member or Non-participating/Non-member: Nothing (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **YOU MUST CALL US FOR PRIOR APPROVAL BEFORE RECEIVING ANY OUTPATIENT PROFESSIONAL OR OUTPATIENT FACILITY CARE FROM PREFERRED PROVIDERS.** We will provide you with the names and phone numbers of several Preferred providers and tell you how many visits we are initially approving. You may then choose which of those providers you would like to see.
- **Under Standard Option,** the calendar year deductible or, for facility care, the inpatient per admission copay, applies to almost all benefits in this Section. We added "(No deductible)" to show when the deductible does not apply.
- **Under Standard Option,** there is a maximum of 25 visits per year for office visits, partial hospitalization, intensive outpatient treatment, and other hospital outpatient treatment. The first 25 visits under Standard Option each calendar year by Preferred providers and Non-preferred providers count toward this maximum. This maximum may be waived for services received from Preferred providers.
- **Under Standard Option,** you may choose to get care In-Network (Preferred) or Out-of-Network (Non-preferred). Cost-sharing and limitations for In-Network (Preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
- **Under Basic Option,** there is **no calendar year deductible**.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3. Some other services also require prior approval. See the instructions after the benefits descriptions below.
- **Standard Option and Basic Option benefits** for Preferred (In-Network) mental health and substance abuse care begin below and are continued on the following pages. Standard Option benefits for Non-preferred (Out-of-Network) care begin on page 85.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preferred (In-Network) benefits	**Standard Option**	**Basic Option**
All diagnostic and treatment services for which prior approval is obtained. ***Note:*** Preferred benefits are payable only when we determine that the care is clinically appropriate to treat your condition and only when you receive the care from a Preferred provider.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Professional services, including individual or group therapy by psychiatrists, psychologists, clinical social workers, or psychiatric nurses • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation ***Note:*** Additional types of licensed providers may be available to you for mental health and substance abuse services. Consult your PPO directory or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.	$20 copayment for the visit (No deductible)	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay a $50 copayment for outpatient services billed for by a facility. ***Note:*** You pay 30% of the Plan allowance for drugs and supplies.
• Pharmacotherapy (medication management) • Psychological testing	Preferred: $20 copayment for the office visit charge (No deductible)	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies.
• Inpatient professional visits • Professional charges for facility-based intensive outpatient treatment	15% of the Plan allowance	Nothing
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting	15% of the Plan allowance	Preferred: $30 copayment per visit
• Professional charges for outpatient diagnostic tests	15% of the Plan allowance	Nothing
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests ***Note:*** You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$200 per admission copayment (No deductible)	$100 per day copayment up to $500 per admission

Preferred (In-Network) benefits - continued on next page

Benefit Description	You Pay	
Preferred (In-Network) benefits (cont.)	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a hospital or other covered facility • Diagnostic tests • Services in the following approved treatment programs (must be prior approved): - partial hospitalization - facility-based intensive outpatient treatment	15% of the Plan allowance	$50 copayment per day per facility ***Note:*** For outpatient diagnostic or psychological tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:*** You pay 30% of the Plan allowance for drugs.
Not covered: • *Services we have not approved* • *Educational or training services* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Light boxes*	*All charges*	*All charges*

Authorization Procedures

Standard and Basic Options: To be eligible to receive Preferred mental health and substance abuse benefits, you must obtain prior approval (see below) and you must use a Preferred provider.

To locate a Preferred provider, please refer to your PPO directory, visit our Web site at www.fepblue.org, or contact us at the mental health and substance abuse phone number shown on the back of your ID card.

Precertification

You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty. Please refer to the precertification information listed in Section 3 for additional information.

Prior Approval

Standard and Basic Options: Prior approval is required for all outpatient mental health and substance abuse services.

To obtain prior approval, you, someone acting on your behalf, your physician, or your hospital must call us at the mental health and substance abuse phone number on the back of your ID card, **prior to starting treatment**. We will provide the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving. We will not provide Preferred benefits for mental health and substance abuse services, even at Preferred facilities, until you obtain prior approval.

Treatment Plans

Standard and Basic Options: In order to maximize your benefits, we may request a treatment plan from your provider.

Preferred Limitation

Under Standard Option, if you do not obtain prior approval, we will provide only Non-preferred (out-of-network) benefits.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Non-preferred (Out-of-Network) benefits	**Standard Option**	**Basic Option**
Professional services, including individual or group therapy, by psychiatrists, psychologists, clinical social workers, or psychiatric nurses. All other types of Non-preferred providers are considered noncovered. As noted on page 87, if you use the services of a noncovered provider, no benefits are available. Call the Mental Health/Substance Abuse number on the back of your ID card to locate a Preferred provider. • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation	40% of the Plan allowance for up to 25 outpatient visits per calendar year; all charges after 25 visits*. You may also be responsible for any difference between the Plan allowance and the billed amount. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Non-participating: You pay all charges
Other services: • Pharmacotherapy (medication management) • Psychological testing	30% of the Plan allowance. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Other services are not subject to the 25-visit limitation.	Participating/Non-participating: You pay all charges
Inpatient visits	40% of the Plan allowance up to 100 days per calendar year; all charges after 100 days. You may also be responsible for any difference between the Plan allowance and the billed amount.	Participating/Non-participating: You pay all charges
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$400 copayment per day (No deductible) up to 100 days per calendar year, plus any difference between our allowance and the billed amount; all charges after 100 days	Member/Non-member: You pay all charges
Outpatient services provided and billed by a hospital or other covered facility • Psychological testing	30% of the Plan allowance, plus any difference between the Plan allowance and the billed amount ***Note:*** Psychological testing is not subject to the visit limitations.	Member/Non-member: You pay all charges (except as noted below)

Non-preferred (Out-of-Network) benefits - continued on next page

Benefit Description	You Pay	
Non-preferred (Out-of-Network) benefits (cont.)	**Standard Option**	**Basic Option**
		Note: For outpatient diagnostic or psychological tests billed for by a Preferred, Member, or Non-member facility, you pay nothing.
Partial hospitalization and intensive outpatient treatment	30% of the Plan allowance, plus any difference between the Plan allowance and the billed amount; all charges after 25 visits* ***Note:*** Visits that you pay for while meeting your deductible count toward the limit cited above. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Member or Non-participating/Non-member: You pay all charges
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	Non-preferred facility: $400 copayment per day, plus any difference between our allowance and the billed amount (No deductible); all charges after 28 days per lifetime Non-preferred professional: 40% of the Plan allowance; all charges after 28 days per lifetime. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime.	Member/Non-member: You pay all charges Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services* • *Services performed by a noncovered provider*	*All charges*	*All charges*

Non-preferred (Out-of-Network) benefits - continued on next page

Benefit Description	You Pay	
Non-preferred (Out-of-Network) benefits (cont.)	**Standard Option**	**Basic Option**
• *Testing and treatment for learning disabilities and mental retardation* • *Services performed or billed by schools, residential treatment centers, halfway houses, or members of their staffs* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Light boxes*	*All charges*	*All charges*

Lifetime maximum	Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime under **Standard Option**.
Precertification	You must get precertification of the medical necessity of your admission to a hospital or other covered facility. Report emergency admissions within two business days following the day of admission, even if you have been discharged. Otherwise, benefits will be reduced by $500. See Section 3 for more information on precertification.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about catastrophic protection for mental health and substance abuse benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting Non-preferred claims.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 90.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program or Mail Service Prescription Drug Program. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible**.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically. Please refer to the prior approval information shown on page 94 of this Section and in Section 3.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. See page 94 of this Section for more information about this important program.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **Under Standard Option,** PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
- Please note that retail pharmacies and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. Refer to page 88 for information about locating Preferred pharmacies.
- **Under Standard Option,** you may use the Mail Service Prescription Drug Program to fill your prescriptions.
- **Under Basic Option,** the Mail Service Prescription Drug Program **is not** available.

We will send each new enrollee a combined prescription drug/Plan identification card. Standard Option members are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States or Puerto Rico, or a nurse practitioner in states that permit it, must write your prescriptions [see Section 5(i) for drugs purchased overseas].
- **Where you can obtain them.**

Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, through a Preferred internet pharmacy, at a Non-preferred retail pharmacy, or through our Mail Service Prescription Drug Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, a Preferred internet pharmacy, or our Mail Service Prescription Drug Program.

Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through a Preferred internet pharmacy in order to receive benefits.

- **We use an open formulary.** This is a list of preferred drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our formulary list.

Under Standard Option, we may ask your doctor to substitute a formulary drug in order to help control costs. We cover drugs that require a prescription (whether or not they are on our formulary list). Your cooperation with our cost-savings efforts helps keep your premium affordable.

Under Basic Option, we encourage you to ask your physician to prescribe a brand-name drug from our formulary list when your physician believes a brand-name drug is necessary or when there is no generic equivalent available. If you purchase a drug that is not on our formulary list, your cost will be higher. (We cover drugs that require a prescription whether or not they are on our formulary list.)

Note: Before filling your prescription, please check the formulary status of your medication. Other than changes resulting from new drugs or safety issues, the formulary list is updated once a year. Prescription drugs are reviewed by the Plan for safety and clinical efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. Using lower cost formulary drugs will provide you with a high quality, cost-effective prescription drug benefit.

Our payment levels are generally categorized as:

Level I: Includes generic drugs

Level II: Includes formulary or preferred brand-name drugs

Level III: Includes non-formulary or non-preferred brand-name drugs

You can view our formulary on our Web site at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

Standard Option: By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

Basic Option: By filling your prescriptions (or those of family members covered by the Plan) at a Preferred retail pharmacy or through a Preferred internet pharmacy, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. In most cases, they must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration (FDA) sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs. However, you and your doctor have the option to request a brand-name drug even if a generic option is available. Using the most cost-effective medication saves money.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.
- **These are the dispensing limitations.**

Standard Option: Subject to manufacturer packaging and your prescriber's instructions, you may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. You may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

Basic Option: When you fill a prescription for the first time, you may purchase **up to** a 34-day supply for a single copayment. For additional copayments, you may purchase **up to** a 90-day supply for continuing prescriptions and for refills.

Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 90-day supplies of those medications. In most cases, refills cannot be obtained until 75% of the prescription has been used. Call us or visit our Web site if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

- **Important contact information.**

Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-216-5343); or www.fepblue.org.

Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077) or www.fepblue.org.

Benefits Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Covered medications and supplies	**Standard Option**	**Basic Option**
• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase ***Note:*** See Section 5(a), page 47, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube. • Insulinand and diabetic test strips • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia • Drugs to aid smoking cessation that require a prescription by Federal law ***Note:*** Prior approval is required if drug treatment extends beyond the initial course of treatment. See Section 3 for more information. • Contraceptive drugs and devices, limited to: - Depo-Provera* - Diaphragms and contraceptive rings* - Intrauterine devices (IUDs) - Implantable contraceptives* - Oral and transdermal contraceptives *available only through retail and internet pharmacies ***Note:*** See *Family planning* in Section 5(a).	See following pages	See following pages
• Influenza vaccine (one each flu season) provided by a Preferred retail pharmacy	Preferred retail pharmacy: Nothing	Preferred retail pharmacy: Nothing

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
	Non-preferred retail pharmacy: You pay all charges	Non-preferred retail pharmacy: You pay all charges
Here is how to obtain your prescription drugs and supplies: **Preferred Retail Pharmacies** • Make sure you have your Plan ID card when you are ready to purchase your prescription • Go to any Preferred retail pharmacy, or • Visit our Web site, www.fepblue.org, select the "Pharmacy" page, and click on the "Retail Pharmacy" link for your enrollment option (Standard or Basic) to fill your prescription and receive home delivery • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site, www.fepblue.org ***Note:*** Please be sure to request the Preferred retail or internet pharmacy listing for your specific option. Retail and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. ***Note:*** Retail and internet pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies. ***Note:*** For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for retail pharmacy-obtained prescription drugs, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077). **For benefit information about prescription drugs supplied by Non-preferred pharmacies, please refer to the next page.**	Level I (generic drug): 20% of the Plan allowance Level II & Level III (brand-name drug): 30% of the Plan allowance	**First-time purchase of a new prescription** up to a 34-day supply: Level I (generic drug): $10 copayment Level II (formulary or preferred brand-name drug): $35 copayment Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum) **Refills or continuing prescriptions** up to a 90-day supply: Level I (generic drug): $10 copayment for each purchase of up to a 34-day supply ($30 copayment for 90-day supply) Level II (formulary or preferred brand-name drug): $35 copayment for each purchase of up to a 34-day supply ($105 copayment for 90-day supply) Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum for each purchase of up to a 34-day supply, or $135 minimum for 90-day supply) ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug.

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
Note: For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payer, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org.	Level I (generic drug): 20% of the Plan allowance Level II & Level III (brand-name drug): 30% of the Plan allowance	**First-time purchase of a new prescription** up to a 34-day supply: Level I (generic drug): $10 copayment Level II (formulary or preferred brand-name drug): $35 copayment Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum) **Refills or continuing prescriptions** up to a 90-day supply: Level I (generic drug): $10 copayment for each purchase of up to a 34-day supply ($30 copayment for 90-day supply) Level II (formulary or preferred brand-name drug): $35 copayment for each purchase of up to a 34-day supply ($105 copayment for 90-day supply) Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum for each purchase of up to a 34-day supply, or $135 minimum for 90-day supply) ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug. ***Note:*** When a therapeutically equivalent generic product becomes available, we may classify the Level II brand-name product as a Level III brand-name drug in determining how much you pay for the drug.

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
		Note: For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.
Non-preferred Retail Pharmacies	45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount ***Note:*** If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.	*All charges*
Mail Service Prescription Drug Program Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. ***Note:*** Not all drugs are available through the Mail Service Prescription Drug Program.	Mail Service Program: Generic: $10 copayment per generic prescription filled (and/or refill ordered) ***Note:*** The $10 copayment amount is waived for the first 4 generic prescriptions filled (and/or refills ordered) per calendar year. Brand-name: $65 for first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year; $50 per brand-name prescription/refill thereafter ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug.	No benefit ***Note:*** You may request home delivery of your internet prescription drug purchases. See page 91 of this Section for our payment levels for drugs obtained through Preferred retail and internet pharmacies.

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
	Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.	
Drugs from other sources • Covered prescription drugs and supplies not obtained at a retail pharmacy, through an internet pharmacy, or, for Standard Option only, through the Mail Service Prescription Drug Program ***Note:*** Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. ***Note:*** For covered prescription drugs and supplies purchased outside of the United States and Puerto Rico, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services. • Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: - Physician's office – Section 5(a) - Hospital (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) • Please refer to page 91 for retail pharmacy-obtained prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility	Preferred: 15% of the Plan allowance (calendar year deductible applies) Participating/Member: 30% of the Plan allowance (calendar year deductible applies) Non-participating/Non-member: 30% of the Plan allowance (calendar year deductible applies); plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Member or Non-participating/Non-member: You pay all charges
Patient Safety and Quality Monitoring (PSQM) We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include: • Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them.		

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
• Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills. • Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines. For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our Web site at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). **Prior Approval** As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), **you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage**. In providing prior approval, we may limit benefits to quantities prescribed in accordance with accepted standards of medical, dental, or psychiatric practice in the United States. Prior approval must be renewed periodically. To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our Web site at www.fepblue.org. Please read Section 3 for more information about prior approval. ***Note:*** If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.		
Not covered: • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs and supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your State law*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
Note: *See Section 5(a), page 47, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Drugs for which prior approval has been denied or not obtained* • *Infant formula other than described on page 47* • *Drugs and supplies related to sex transformations, sexual dysfunction, or sexual inadequacy* • *Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the primary payer for any covered services and your FEDVIP Plan will be secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*,for additional information.
- **Under Standard Option,** the calendar year deductible applies only to the accidental injury benefit below. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- ***Note:*** We cover inpatient and outpatient hospital care, as well as anesthesia administered at the facility, to treat children up to age 22 with severe dental caries. We cover these services for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.

Accidental injury benefit	You Pay	
Accidental injury benefit	**Standard Option**	**Basic Option**
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. ***Note:*** An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. ***Note:*** A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	Preferred: 15% of the Plan allowance (calendar year deductible applies) Participating: 30% of the Plan allowance (calendar year deductible applies) Non-participating: 30% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$25 copayment ***Note:*** **We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 101.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, refer to the Preferred provider directory, visit our Web site at www.fepblue.org, or call us at the customer service number on the back of your ID card. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following pages. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use Non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see above).

Standard Option dental benefits	Standard Option Only		
Covered service	**We Pay**	**We Pay**	**You pay**
Clinical oral evaluations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Periodic oral evaluation*	$12	$8	
Limited oral evaluation	$14	$9	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
**Limited to two per person per calendar year*			

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
	To age 13	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
	$12	$8	
	$14	$9	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
	$14	$9	
	$14	$9	
Radiographs	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Intraoral complete series	$36	$22	
Intraoral periapical first film	$7	$5	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Intraoral periapical each additional film	$4	$3	
Intraoral occlusal film	$12	$7	
Extraoral first film	$16	$10	
Extraoral each additional film	$6	$4	
Bitewing – single film	$9	$6	
Bitewings – two films	$14	$9	
Bitewings – four films	$19	$12	
Bitewings – vertical	$12	$7	
Posterior-anterior or lateral skull and facial bone survey film	$45	$28	
Panoramic film	$36	$23	
Tests and laboratory exams	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Pulp vitality tests	$11	$7	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Palliative treatment	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Palliative (emergency) treatment of dental pain – minor procedure	$24	$15	
Sedative filling	$24	$15	

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
			Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Preventive	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Prophylaxis – adult*	---	$16	
Prophylaxis – child*	$22	$14	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Topical application of fluoride (prophylaxis not included) – child	$13	$8	
Topical application of fluoride (prophylaxis not included) – adult	---	$8	
**Limited to two per person per calendar year*			
Space maintenance (passive appliances)	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Space maintainer – fixed – unilateral	$94	$59	
Space maintainer – fixed – bilateral	$139	$87	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Space maintainer – removable – unilateral	$94	$59	
Space maintainer – removable – bilateral	$139	$87	
Recementation of space maintainer	$22	$14	
Amalgam restorations (including polishing)	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Amalgam – one surface, primary or permanent	$25	$16	
Amalgam – two surfaces, primary or permanent	$37	$23	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Amalgam – three surfaces, primary or permanent	$50	$31	
Amalgam – four or more surfaces, primary or permanent	$56	$35	

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
Filled or unfilled resin restorations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Resin – one surface, anterior	$25	$16	
Resin – two surfaces, anterior	$37	$23	
Resin – three surfaces, anterior	$50	$31	
Resin – four or more surfaces or involving incisal angle (anterior)	$56	$35	
Resin-based composite – one surface, posterior	$25	$16	
Resin-based composite – two surfaces, posterior	$37	$23	
Resin-based composite – three surfaces, posterior	$50	$31	
Resin-based composite – four or more surfaces, posterior	$50	$31	
Inlay restorations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Inlay – metallic – one surface	$25	$16	
Inlay – metallic – two surfaces	$37	$23	
Inlay – metallic – three or more surfaces	$50	$31	
Inlay – porcelain/ceramic – one surface	$25	$16	
Inlay – porcelain/ceramic – two surfaces	$37	$23	
Inlay – porcelain/ceramic – three or more surfaces	$50	$31	
Inlay – composite/resin – one surface	$25	$16	
Inlay – composite/resin – two surfaces	$37	$23	
Inlay – composite/resin – three or more surfaces	$50	$31	

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
Other restorative services	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left *Note:* For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Pin retention – per tooth, in addition to restoration	$13	$8	
Extractions – includes local anesthesia and routine post-operative care			
Extraction, erupted tooth or exposed root	$30	$19	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43	$27	
Surgical removal of residual tooth roots (cutting procedure)	$71	$45	
General anesthesia in connection with covered extractions	$43	$27	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a $20 copayment for each evaluation, and we pay any balances in full. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, please refer to the Preferred provider directory, visit our Web site at ww.fepblue.org, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits	Basic Option Only	
Covered service	**We Pay**	**You Pay**
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Radiographs Intraoral – complete series including bitewings (*limited to 1 complete series every 3 years*) Bitewing – single film* Bitewings – two films*	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges

Covered service - continued on next page

Basic Option dental benefits	Basic Option Only	
Covered service (cont.)	**We Pay**	**You Pay**
Bitewings – four films* *Benefits are limited to a combined total of 4 films per person per calendar year	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Preventive Prophylaxis – adult *(up to 2 per calendar year)* Prophylaxis – child *(up to 2 per calendar year)** Topical application of fluoride (prophylaxis not included) – child *(up to 2 per calendar year)* Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)*	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Special features

Special feature	Description
Flexible benefits option	Under the Blue Cross and Blue Shield Service Benefit Plan, our Case Management process may include a **flexible benefits option**. This option allows nurse case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. Members who are eligible to receive services through the flexible benefits option are asked to provide verbal consent for the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an **alternative benefits agreement** that includes the terms listed below. • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with the review process. • If we approve alternative benefits, we cannot guarantee that they will be extended beyond the limited time period and/or scope of treatment initially approved or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the **alternative benefits agreement**, we may withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. If you sign the **alternative benefits agreement**, we will provide the agreed-upon benefits for the stated time period, unless we are misled by the information given to us. You may request an extension of the time period initially approved for alternative benefits, but benefits as stated in this brochure will apply if we do not approve your request. Please note that the written **alternative benefits agreement** must be signed by the member or his/her authorized representative and returned to the Plan case manager within 30 days of the date of the alternative benefits agreement. If the Plan does not receive the signed agreement within 30 days, alternative benefits will be withdrawn and benefits as stated in this brochure will apply.
Visit our new Web site!	We are pleased to announce that we have enhanced our Web site – www.fepblue.org – to better serve the health care needs of our Service Benefit Plan members. Now you can use the site to manage your health and your health care benefits with ease. Whether it's comparing benefit plans, choosing the coverage that best meets the needs of you and your family, or locating a provider near your home, www.fepblue.org allows you to understand your options and make informed decisions. Click on the new "My Blue" section to easily access a wide range of services such as checking the status of your claims, requesting claim forms, ordering a duplicate or replacement Service Benefit Plan ID card, changing your address of record, or finding the telephone number to talk to one of our customer service representatives. Visit the new health and wellness section for valuable information about healthy behaviors and lifestyles. The new www.fepblue.org is designed to give you quick access to the information you're looking for so that you can more easily understand and manage your health care benefits and your health care needs. That's why you'll find new search tools and easy-to-use features like the ability to increase text size at the touch of a button, print pages quickly, and e-mail Web site content. We hope you visit the new www.fepblue.org and take advantage of its many resources!

Special feature	Description
Blue Health Connection	Stay connected to your health and get the answers you need when you need them by using Blue Health Connection 24 hours a day, 365 days a year. This service offers you direct communication with a Registered Nurse by calling 1-888-258-3432 toll-free, or by accessing our Web site, www.fepblue.org. Blue Health Connection provides one-stop shopping for health information and health care management. You can check your symptoms with the Symptoms Checker, read information about healthy eating and weight loss, and listen to a range of health-related topics from the AudioHealth Library. In addition, you can complete a quick online Health Assessment that will help you look at your personal health, review your family history, and obtain personalized suggestions about health-related behaviors to improve or maintain your health and wellness. Please keep in mind that benefits for any health care services you may seek after using Blue Health Connection are subject to the terms of your coverage under this Plan.
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Web accessibility for the visually impaired	Our Web site, www.fepblue.org, adheres to the most current Section 508 Web accessibility standards to ensure that visitors with visual impairments can use the site with ease. Select the "Web Accessibility" link and take advantage of special captioning, audio descriptions, screen reader optimization, enlarged text options, and high color contrast for enhanced visibility.
Travel benefit/services overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States and Puerto Rico.
Health support programs	The Service Benefit Plan offers patient education and support programs for certain diagnoses in select locations. Call the customer service number on the back of your ID card to find out what programs are available in your area.
Healthy Families Program	Healthy Families is a national health education prevention program that provides educational mailings to members and their families to help adopt healthy behaviors, reduce risk of injury and disease, and improve existing chronic conditions.
***WalkingWorks®* Wellness Program**	*WalkingWorks®* can help you walk your way to better health through online tools and resources that encourage you to incorporate walking into your daily routine and to set – and achieve – personal wellness goals. Receive a pedometer to count your daily steps and then record your progress with the online *WalkingWorks* tracking tool. Log in at www.fepblue.org and start walking your way to better health. If you do not have access to the internet, please call us at 1-888-706-2583. *WalkingWorks* was developed in cooperation with the President's Council on Physical Fitness and Sports.

Section 5(i). Services, drugs, and supplies provided overseas

If you travel or live outside the United States and Puerto Rico, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this Section, the same definitions, limitations, and exclusions also apply. See below and page 105 for the claims information we need to process overseas claims. We may request that you provide complete medical records from your provider to support your claim.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care outside the United States.

Overseas claims payment

For professional care you receive overseas, we provide benefits at Preferred benefit levels using an Overseas Fee Schedule as our Plan allowance. **Under Standard Option,** you must pay any difference between our payment and the amount billed, in addition to any applicable deductible, coinsurance, and/or copayment amounts. You must also pay any charges for noncovered services.

Under Basic Option, you pay any difference between our payment and the amount billed, as well as the applicable copayment or coinsurance. You must also pay any charges for noncovered services. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States and Puerto Rico.**

For facility care you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 69-71.

For dental care you receive overseas, we provide benefits as described in Section 5(g). **Under Standard Option,** you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option,** you must pay the $20 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. The Worldwide Assistance Center can help you locate a hospital in our network near where you are staying. You may also view a list of our network hospitals on our Web site, www.fepblue.org. Although we do not have a network of professionals overseas, the Worldwide Assistance Center can also help you locate a physician. You will have to file a claim to us for reimbursement for professional services.

If you are overseas and need assistance locating providers, contact the Worldwide Assistance Center (provided by Mondial Assistance – formerly World Access Service Corporation), by calling the center collect at 1-804-673-1678. Members in the United States, Puerto Rico, or the Virgin Islands should call 1-800-699-4337. Mondial Assistance also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.

Filing overseas claims

- **Hospital and physician care**

Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered hospital and physician services received outside the United States and Puerto Rico, send a completed Overseas Claim Form and itemized bills to: Mailroom Administrator, FEP Overseas Claims, P.O. Box 14133, Lexington, KY 40512-4113. We will provide translation and currency conversion services for your overseas claims. Send any written inquiries concerning the processing of your overseas claims to this address or call us at 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. You may also obtain Overseas Claim Forms from this address, from our Web site (www.fepblue.org), or from your Local Plan.

Filing overseas claims

- **Pharmacy benefits**

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States and Puerto Rico, send a completed FEP Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills, to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057. We will provide translation and currency conversion services for your overseas claims. You may obtain claim forms for your drug purchases by writing to this address, by visiting our Web site, www.fepblue.org, or by calling 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. Send any written inquiries concerning drugs you purchase to this address as well.

Please note that under both **Standard and Basic Options**, you may fill your prescriptions through a Preferred internet pharmacy only if the prescribing physician is licensed in the United States or Puerto Rico.

Under Standard Option, you may order your prescription drugs from the Mail Service Prescription Drug Program only if:

- Your address includes a U.S. zip code (such as with APO and FPO addresses and in U. S. territories) and
- The prescribing physician is licensed in the United States or Puerto Rico.

Please see page 92 for more information about using this program.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim for

these services. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines.

For additional information, contact us at the phone number on the back of your ID card or visit our Web site at www.fepblue.org.

Discount Drug Program
The Discount Drug Program is available to Service Benefit Plan enrollees at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 20%. The program permits you to obtain discounts on the following drugs:

For sexual dysfunction: Caverject injection, Cialis tablet, Edex injection, Levitra tablet, Muse suppository, and Viagra tablet;
For weight loss: Meridia capsule and Xenical capsule;
For hair removal: Vaniqa cream;
For hair growth: Propecia; and
For pigmenting/depigmenting: Alustra, Benoquin, Eldoquin, Epiquin Micro, Solaquin, Tretinoin, and Tri-Luma.

Drugs may be added to this list as they are approved by the Food and Drug Administration (FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy. The pharmacist will ask you for payment in full at the negotiated discount rate. If you have any questions, please call 1-800-624-5060.

Federal DentalBlue
Federal DentalBlue is an optional dental product with an additional premium that supplements the dental benefits included in your Service Benefit Plan coverage. To apply for Federal DentalBlue, you must be:

1.1. Enrolled in Standard Option and reside in one of the following Plan areas: Alabama, Illinois, New Mexico, Oklahoma, Texas, or in the counties of Clallam, Columbia, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, or Yakima in Washington State; or

2.2. Enrolled in Basic Option and reside in one of the following Plan areas: Alabama, Illinois, New Mexico, Oklahoma, or Texas.

To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your local Blue Cross and Blue Shield Plan. For more information on Federal DentalBlue, please contact us at:
Alabama: 1-800-492-8872 or www.bcbsal.org
Illinois: 1-866-431-1595 or www.yourfederaldental.com
New Mexico: 1-866-431-1604 or www.yourfederaldental.com
Oklahoma: 1-866-431-1602 or www.yourfederaldental.com
Texas: 1-866-431-1598 or www.yourfederaldental.com
Washington State Counties: 1-888-224-4366

Vision Care Affinity Program
Service Benefit Plan members can receive routine eye exams, frames, lenses, conventional contact lenses, and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to over 27,000 providers including optometrists, ophthalmologists, and many retail centers. For a complete description of the program or to find a provider near you, visit us at www.fepblue.org or call **1-800-551-3337**between 8:00 a.m. and 11:00 p.m. eastern time, M-F;

9:00 a.m. to 4:00 p.m. on Sat.; and noon to 4:00 p.m. on Sun. Members can save on replacement contact lenses by visiting www.lens123.com or calling 1-800-536-7123. Members can also save up to 25% off the **provider's usual fee**, or 5% off sales pricing, on laser vision correction procedures. Call **1-800-551-3337**for the nearest location and authorization for the discount.

Medicare Advantage Plan Enrollment
Some local Blue Cross and Blue Shield Plans offer Medicare recipients the opportunity to enroll in a Medicare Advantage plan without payment of an FEHB premium. Contact your local Blue Cross and Blue Shield Plan for more information.

SNAPforSeniors®
SNAPforSeniors® (**S**earch **N**ew **A**vailable **P**laces) simplifies the difficult process of finding appropriate senior housing options by providing members with the Senior Housing Locator – an online tool to access a current, comprehensive database of more than 60,000 senior housing communities. By using the Senior Housing Locator, you can search for assisted living communities, residential care, nursing homes, continuing care retirement communities, and independent living communities anywhere in the nation. You can personalize your housing choices to best match the services and amenities available in each community to your lifestyle and health needs. The Senior Housing Locator can be accessed via www.fepblue.org.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants)**.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction);
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB Program;
- Services, drugs, or supplies you would not be charged for if you had no health insurance coverage;
- Services, drugs, or supplies you receive without charge while in active military service;
- Amounts charged that neither you nor we are legally obligated to pay, such as amounts over the Medicare limiting charge or equivalent Medicare amount as described in Section 4 under *Your costs for covered services*, or State premium taxes, however applied;
- Services, drugs, or supplies you receive from immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption;
- Services or supplies (except for medically necessary prescription drugs) that you receive from a noncovered facility, such as an extended care facility or nursing home, except as specifically described in Sections 5(a) and 5(c);
- Services, drugs, or supplies you receive from noncovered providers except in medically underserved areas as specifically described on page 12;
- Services, drugs, or supplies you receive for cosmetic purposes;
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits and diagnostic tests for the treatment of morbid obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures (see page 52); and, those nutritional counseling services specifically listed on pages 30, 50, and 67;
- Services you receive from a provider that are outside the scope of the provider's licensure or certification;
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*;
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome;
- Services of standby physicians;
- Self-care or self-help training;
- Custodial care;
- Personal comfort items such as beauty and barber services, radio, television, or telephone;
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs;

- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under *Preventive care, adult and child* in Sections 5(a) and 5(c) and screenings specifically listed on pages 32-34;
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay;
- Topical Hyperbaric Oxygen Therapy (THBO);
- Physician charges for shift differentials; or
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service number on the back of your Service Benefit Plan ID card, or at our Web site at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing hospital stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note:Canceled checks, cash register receipts, balance due statements, or bills you prepare yourself are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) form you received from any primary payer [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, home nursing care, and physical, occupational, and speech therapy, require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through a Preferred internet pharmacy, or through the Mail Service Prescription Drug Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See below for information on how to obtain benefits from the Retail Pharmacy Program, a Preferred internet pharmacy, and the Mail Service Prescription Drug Program.)

Prescription drug claims

Preferred Retail/Internet Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred internet pharmacies, go to our Web site, www.fepblue.org, visit the "Pharmacy" page, and click on the "Retail Pharmacy" link for your enrollment option (Standard or Basic) to fill your prescriptions and receive home delivery. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail or internet pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 17).

See the following paragraph for claim filing instructions.

Non-Preferred Retail/Internet Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail or internet pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail or internet pharmacies.

Mail Service Prescription Drug Program

Standard Option: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

(1) Complete the initial mail order form;

(2) Enclose your prescription and copayment;

(3) Mail your order to Medco, P.O. Box 30496, Tampa, FL 33633-1524; and

(4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890

(TDD: 1-800-216-5343). You will be billed later for the copayment.

After that, to order refills either call the same number or access our Web site at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow approximately one week for delivery on refills.

Basic Option: The Mail Service Prescription Drug Program **is not** available under Basic Option.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 104 and 105 of this brochure.

When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for precertification or prior approval required by Section 3:

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at the address shown on your explanation of benefits (EOB) form. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program or Mail Service Prescription Drug Program); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or b) Write to you and maintain our denial – go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 1, 1900 E Street, NW, Washington, DC 20415-3610. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and

- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We have not responded yet to your initial claim or request for precertification/prior approval, then call us at the customer service number on the back of your Service Benefit Plan ID card and we will expedite our review; or

b) We denied your initial claim or request for precertification/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 1 at 1-202-606-0727 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payer and we are the secondary payer.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payer's benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payer (see Section 4). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible (under Standard Option) and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payer.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 116.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

(Please refer to page 23 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 16 for exception).

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When the Original Medicare Plan is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for the covered charges. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our Web site at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
  - Inpatient hospital per-admission copayments;
  - Inpatient Non-member hospital coinsurance; and
  - Non-preferred inpatient per-day copayments for mental conditions/substance abuse care.
- Under **Basic Option**, we will waive our:
  - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
  - Calendar year deductible;
  - Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient, including mental conditions and substance abuse care);
  - Copayments for office visits to Preferred physicians and other health care professionals;
  - Copayments for routine physical examinations and preventive (screening) services performed by Preferred physicians, other health care professionals, and facilities; and
  - Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions and substance abuse care.
- Under **Basic Option**, we will waive our:
  - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

  A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

  Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

  Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 14 for the exceptions to this requirement.

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **Medicare prescription drug coverage (Part B)**

  This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we provide benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representativesobtain (whether by lawsuit, settlement, insurance or benefit program claims, orotherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include,if applicable, your heirs, administrators, legal representatives, parents (if you are a minor),successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

- We will not reduce our share of any recovery unless,in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
  - Uninsured and underinsured motorist coverage
  - Workers' Compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 10. Definitions of terms we use in this brochure

Accidental injury An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. ***Note:*** Injuries to the teeth while eating are **not** considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.

Admission The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.

Assignment An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.

Calendar year January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Carrier The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.

Case management A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America, 2002). Each Blue Cross and Blue Shield Plan administers a case management program to assist Service Benefit Plan members with certain complex and/or chronic health issues. Each program is staffed by licensed health care professionals (Case Managers) and is accredited by URAC. For additional information regarding case management, call us at the telephone number listed on the back of your Service Benefit Plan ID card.

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 18.

Copayment A copayment is a fixed amount of money you pay when you receive covered services. See page 18.

Cosmetic surgery Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services Services we provide benefits for, as described in this brochure.

Custodial care Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could perform safely and reasonably, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;
4. Acting as companion or sitter;
5. Supervising medication that can usually be self-administered; or

6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

Custodial care that lasts 90 days or more is sometimes known as Long Term Care. The Carrier, its medical staff, and/or an independent medical review determine which services are custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 18.

Durable medical equipment

Equipment and supplies that:

1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and, approval for marketing has not been given at the time it is furnished. ***Note:*** Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if:

1. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
2. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only:

- published reports and articles in the authoritative medical and scientific literature;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Each Local Plan has a Medical Review department that determines whether a claimed service is experimental or investigational after consulting with internal or external experts or nationally recognized guidelines in a particular field or specialty.

For more detailed information, contact your Local Plan at the customer service telephone number located on the back of your Service Benefit Plan ID card.

Group health coverage Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than $200 per day for hospitalization (including extension of any of these benefits through COBRA).

Intensive outpatient care A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Lifetime maximum The maximum amount the Plan will pay on your behalf for covered services you receive while you are enrolled in your option. Benefit amounts accrued are accumulated in a permanent record regardless of the number of enrollment changes. Please see page 87.

Local Plan A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.

Medical foods The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medical necessity We determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:

1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury;
2. Consistent with standards of good medical practice in the United States;
3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

Mental conditions/ substance abuse Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

Partial hospitalization An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. If the amount your provider bills for covered services is less than our allowance, we base our payment, and your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers -** Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail and internet pharmacies that contract with Caremark) have agreed to accept as payment in full, when we pay primary benefits.

Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate." The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 97 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)

- **Participating providers -** Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance") is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the "Member rate." The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.
- **Non-participating providers -** We have no agreements with these providers. We determine our allowance as follows:
  - For inpatient services at hospitals, and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is based on the average amount paid nationally on a per day basis to contracting and non-contracting facilities for covered room, board, and ancillary charges for your type of admission. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount;
  - For outpatient, non-emergency surgical services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is the average amount for all outpatient surgical claims that we pay nationally to contracting and non-contracting facilities. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For other outpatient services by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury, our allowance is the billed amount (minus any amounts for noncovered services);

- For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the 2009 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");
- For prescription drugs furnished by retail and internet pharmacies that do not contract with Caremark, our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth in the most current version of First DataBank's National Drug Data File; and
- For services you receive outside of the United States and Puerto Rico from providers that do not contract with us or with Mondial Assistance, our allowance is an Overseas Fee Schedule that is based on amounts comparable to what Participating providers in the Washington, DC, area have agreed to accept.

Non-participating providers are under no obligation to accept our allowance as payment in full. If you use Non-participating providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances – see below). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment amounts.

Note: For **certain** covered services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

In **only** those situations listed below, when the difference between the NPA and the billed amount for covered Non-participating professional care is greater than $5,000 for an episode of care, your responsibility will be limited to $5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts). An episode of care is defined as all covered Non-participating professional services you receive duringan emergency room visit, an outpatient visit, or a hospital admission (including associated emergency room or pre-admission services),plus your first follow-up outpatient visit to the Non-participating professional provider(s) who performed the service(s) during your hospital admission or emergency room visit.

- When you receive care in a Preferred hospital from Non-participating professional providers such as aradiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, orpediatric sub-specialist;and the professional providers are hospital-based or are specialists recruited from outside the hospital either without your knowledge and/or because they are needed to provide immediate medical or surgical expertise; and
- When you receive care from Non-participating professional providersin a Preferred, Member, or Non-member hospital as a result of a medical emergency or accidental injury (see pages 77 and 79).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 21, 104, and 105.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted to the hospital for inpatient care, or within two business days following an emergency admission.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, and other covered health care professionals (or for retail and internet pharmacies, between pharmacies and Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Prior approval

Written assurance that benefits will be provided by:

1. The Local Plan where the services will be performed;
2. The Retail Pharmacy Program (for prescription drugs and supplies purchased through Preferred retail and internet pharmacies) or the Mail Service Prescription Drug Program; or
3. The Blue Cross and Blue Shield Association Clinical Trials Information Unit for certain organ/tissue transplants we cover only in clinical trials. See Section 5(b).

For more information, see the benefit descriptions in Section 5 and *How to get approval for . . . Other services* on pages 16-17. See Section 5(e) for special authorization requirements for mental health and substance abuse benefits.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care.

Sound natural tooth

A tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Transplant period

A defined number of consecutive days associated with a covered organ/tissue transplant procedure.

Us/We/Our

"Us," "we," and "our" refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.

You/Your

"You" and "your" refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide toFederal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; and
- When the next Open Season for enrollment begins.

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage, or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide toFederal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

  You may not elect TCC if you are fired from your Federal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide toFederal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

  You may convert to a non-FEHB individual policy if:

  - Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or
  - You are not eligible for coverage under TCC or the spouse equity law.

  If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

  Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

  The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

  For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; and refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA. .

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames, and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

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Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2009

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $300 per person ($600 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: 15%* of our allowance; $20 per office visit Non-PPO: 30%* of our allowance	29-31
Services provided by a hospital:		
• Inpatient	PPO: $200 per admission Non-PPO: $300 per admission	66-68
• Outpatient	PPO: 15%* of our allowance (no deductible for surgery) Non-PPO: 30%* of our allowance (no deductible for surgery)	69-71
Emergency benefits:		
• Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	76-78
• Medical emergency	Regular benefits for physician and hospital care* Ambulance transport services: $100 per day for ground ambulance (no deductible); $150 per day for air or sea ambulance (no deductible)	76, 79-80
Mental health and substance abuse treatment	In-Network (PPO): Regular cost-sharing, such as $20 office visit copay (prior approval required); $200 per inpatient admission Out-of-Network (Non-PPO): Benefits are limited	81-87
Prescription drugs	Retail Pharmacy Program: • PPO: 20% of our allowance generic/30% of our allowance brand-name; up to a 90-day supply • Non-PPO: 45% of our allowance (AWP); up to a 90-day supply Mail Service Prescription Drug Program:	88-95

	• $10 generic/$65 brand-name per prescription; up to a 90-day supply	
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	55, 96--100
Special features:	**Special features:** Flexible benefits option; online customer and claims service; Blue Health Connection; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; Healthy Families Program; and *WalkingWorks®* Wellness Program	102-103
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 (PPO) or $7,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	21-22

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2009

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 14. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $25 per office visit for primary care physicians and other health care professionals; $30 per office visit for specialists Non-PPO: You pay all charges	29-31
Services provided by a hospital:		
• Inpatient	PPO: $100 per day up to $500 per admission Non-PPO: You pay all charges	66-68
• Outpatient	PPO: $50 per day per facility Non-PPO: You pay all charges	69-71
Emergency benefits:		
• Accidental injury	PPO: $75 copayment for emergency room care; $30 copayment for urgent care Non-PPO: $75 copayment for emergency room care Ambulance transport services: $100 per day for ground ambulance; $150 per day for air or sea ambulance	76-78
• Medical emergency	Same as for accidental injury	76, 79-80
Mental health and substance abuse treatment	In-Network (PPO): Regular cost sharing, such as $25 office visit copayment (prior approval required); $100 per day up to $500 per inpatient admission Out-of-Network (Non-PPO): You pay all charges	81-87
Prescription drugs:	Retail Pharmacy Program: • PPO: $10 generic/$35 formulary brand-name per prescription/50% coinsurance ($45 minimum) for non-formulary brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments • Non-PPO: You pay all charges	88-95

Basic Option Benefits	You pay	Page
Dental care	PPO: $20 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $25 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	55, 96-97, 101
Special features:	**Special features:** Flexible benefits option; online customer and claims service; Blue Health Connection; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; Healthy Families Program; and *WalkingWorks®* Wellness Program	102-103
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000 (PPO) per contract per year; some costs do not count toward this protection	21-22

2009 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the *Guide to Benefits for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees, and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Standard Option Self Only	104	$155.66	$70.18	$337.26	$152.06	$179.45	$46.39
Standard Option Self and Family	105	$352.56	$164.58	$763.88	$356.59	$406.42	$110.72
Basic Option Self Only	111	$128.00	$42.66	$277.32	$92.44	$147.62	$23.04
Basic Option Self and Family	112	$299.75	$99.91	$649.45	$216.48	$345.71	$53.95

HEALTH BENEFIT BOOKLET

BLUE ACCESS PPO

STATE OF INDIANA

Anthem Traditional Plan II ASO

Administered by Anthem Insurance Companies, Inc.

Anthem Insurance Companies, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

INTRODUCTION

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

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

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

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

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

President

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You Have the Right to:

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

As a Member, You Have the Responsibility to:

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

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

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SCHEDULE OF BENEFITS

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

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

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use a Non-Network Provider you are responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Copayments, Deductibles, and **non Covered** charges.

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

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

DEDUCTIBLE	**Network**	**Non-Network**
Per Member (Single Coverage)	$500	$500
Per Family	$500	$500
	OR	
[*Tobacco Incentive-* Per Member (Single Coverage)	$0	$0
Per Family	$0	$0]

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

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

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

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

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

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

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

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

COVERED SERVICES	COPAYMENTS/COINSURANCE/MAXIMUMS	
	Network	**Non-Network**
Ambulance Services	$50 Copayment	$50 Copayment
Behavioral Health Services Coverage for the Inpatient and Outpatient treatment of Behavioral Health is provided to the same extent and degree as for the treatment of physical illness.		
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia)	Copayments/Coinsurance based on setting where Covered Services are received	40% Coinsurance
Diagnostic Services	When rendered as Physician Home Visits and Office Services or Outpatient Services the Copayment/Coinsurance is based on the setting where Covered Services are received except as listed below. Other Diagnostic Services and/or tests, including services received at an independent Network lab, may not require a Copayment/ Coinsurance. Laboratory services provided by a facility participating in the Administrator's Laboratory Network (as shown in the Provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient Hospital laboratory which is not part of the Administrator's Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.	
NOTE: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received are subject to the Other Outpatient Services Copayment/ Coinsurance regardless of setting where Covered Services are received.		
Emergency Room Services (Copayment/Coinsurance is waived if you are admitted)	$75 Copayment per visit	$75 Copayment per visit
Home Care Services	$20 Copayment per day	40% Coinsurance
Maximum visits per Benefit Period	Unlimited (Network and Non-Network combined)	

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

Private Duty Nursing Lifetime Maximum	$5,000 per Member

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

Maximum per Benefit Period for all Durable Medical Equipment and Orthotics (does not include an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb)	Unlimited (Network and Non-Network combined)
Lifetime Maximum for Prosthetic limbs (includes an orthotic custom fabricated brace or support designed as a component for a Prosthetic limb)	Unlimited (Network and Non-Network combined)

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

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

Outpatient Services		
Other Outpatient Services	No Copayment/Coinsurance up to the Maximum Allowable Amount	40% Coinsurance

Note: Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Outpatient Surgery Hospital/Alternative Care Facility	$250 Copayment per visit	40% Coinsurance

Physician Home Visits and Office Services		
Primary Care Physician (PCP)	$20 Copayment per visit	40% Coinsurance

This Copayment/Coinsurance also applies to the following Covered Services regardless of Outpatient setting where they are received: • Routine and Diagnostic Mammograms • Diabetes self management training • Medical nutritional therapy (Network only)		
Specialty Care Physician (SCP)	$20 Copayment per visit	40% Coinsurance
Allergy Injections	$5 Copayment per visit	40% Coinsurance

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

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

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

Therapy Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received

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

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

Maximum Visits per Benefit Period for:

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

Urgent Care Center Services	$35 Copayment per visit	$35 Copayment per visit. You are responsible for any amounts that exceed the Maximum Allowable Amount.

Human Organ and Tissue Transplant Services

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

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

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

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

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

Covered Transplant Procedure during the Transplant Benefit Period	Network Transplant Provider	Non-Network Transplant Provider
	Copayment/Coinsurance based on place of setting, subject to the $2,000 Out-of-Pocket Limit. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.	During the Transplant Benefit Period, You will pay 40% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also a Network Provider for this Certificate (for services other than Transplant Services and Procedures), then you will **not** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. If the Provider is a Non-Network

		Provider for this Certificate, you **will** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**	**Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**
	Copayment/Coinsurance based on place of setting, subject to the $2,000 Out-of-Pocket Limit.	Not Covered for Transplants received at a Non-Network Transplant Provider Facility
Transportation Lodging and Meals	Covered, as approved by the Plan, up to a $10,000 benefit limit.	You are responsible for 40% of Maximum Allowable Amount after the Deductible has been met.
Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as approved by the Plan, up to a $30,000 benefit limit.	Covered as approved by the Plan, up to a $30,000 benefit limit. You will be responsible for 40% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.
Live Donor Health Services	Covered as determined by the Plan.	You will pay 40% of the Plan's Maximum Allowable Amount for Medically Necessary live organ donor expenses. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement.

Prescription Drugs

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

Retail Pharmacy (Network and Non-Network)	34 days or 100 units of medication (whichever is greater)
Mail Service	90 days
Retail Specialty Pharmacy (Network and Non-Network) and Specialty Mail Service	34 days or 100 units of medication (whichever is greater)

Network Retail Pharmacy Prescription Drug Copayment/Coinsurance

Tier 1 Prescription Drugs	$10 Copayment per Prescription Order
Tier 2 Prescription Drugs	$20 Copayment per Prescription Order
Tier 3 Prescription Drugs	40% Coinsurance (minimum $40 & maximum $100) per Prescription Order
Tier 4 Prescription Drugs	40% Coinsurance(minimum $40 & maximum $100) per Prescription Order

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

Tier 1 Prescription Drugs	$20 Copayment per Prescription Order
Tier 2 Prescription Drugs	$40 Copayment per Prescription Order
Tier 3 Prescription Drugs	40% Coinsurance(minimum $80 & maximum $150) per Prescription Order
Tier 4 Prescription Drugs	40% Coinsurance(minimum $80 & maximum $150) per Prescription Order

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

Tier 1 Specialty Prescription Drug	$10 Copayment per Prescription Order
Tier 2 Specialty Prescription Drug	$20 Copayment per Prescription Order
Tier 3 Specialty Prescription Drug	40% Coinsurance (minimum $40 & maximum $100) per Prescription Order

Tier 4 Specialty Prescription Drug	40% Coinsurance (minimum $40 & maximum $100) per Prescription Order
Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Copayment/Coinsurance:	40% Coinsurance per Prescription Order

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

COVERED SERVICES

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

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

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

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

Ambulance Services

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

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

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

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

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

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

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

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

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

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

Behavioral Health Services

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

Covered Services include but are not limited to:

- **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

- **Partial hospitalization -** an intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

- **Intensive Outpatient treatment or day treatment -** a structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.

- **Outpatient treatment, or individual or group treatment -** office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family-therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

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

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

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

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

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

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

Dental Services

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

Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

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

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

Other Dental Services

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

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

Diagnostic Services

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

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

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

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

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

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

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

Emergency Care and Urgent Care Services

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

Emergency Care (including Emergency Room Services)

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

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

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

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

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

Urgent Care Center Services

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

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

See your Schedule of Benefits for benefit limitations.

Home Care Services

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

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

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

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

Non Covered Services include but are not limited to:

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

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

Hospice Services

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

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

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

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

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Inpatient Services

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

Inpatient Services include:

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

Room, Board, and General Nursing Services

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

Ancillary (Related) Services

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

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

Professional Services

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

Copayment Waiver

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

Maternity Services

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

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

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

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

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

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

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

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

  1. the antepartum, intrapartum, and postpartum course of the mother and infant;
  2. the gestational stage, birth weight, and clinical condition of the infant;
  3. the demonstrated ability of the mother to care for the infant after discharge; and
  4. the availability of postdischarge follow-up to verify the condition of the infant after discharge.

- **Covered Services include at-home post delivery care visits** at your residence by a Physician or Nurse performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

  1. parent education;
  2. assistance and training in breast or bottle feeding; and
  3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

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

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

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

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

Medical Supplies, Durable Medical Equipment, and Appliances

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

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

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

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

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

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

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

Covered Services may include, but are not limited to:

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

  Covered Services may include, but are not limited to:

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

  Non Covered Services include but are not limited to:

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

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

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

  Covered Services may include, but are not limited to:

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

  Non Covered items may include but are not limited to:

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

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

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

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

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

Covered Services may include, but are not limited to:

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

Non Covered Prosthetic appliances include but are not limited to:

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

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

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

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

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

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

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

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

  Non Covered Services include but are not limited to:

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

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

- **Prosthetic limbs & Orthotic custom fabricated brace or support -** Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1. determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
  2. not solely for comfort or convenience.

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

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

Outpatient Services

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

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

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

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

Pervasive Developmental Disorder Services

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

Physician Home Visits and Office Services

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

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

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

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

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

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

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

Preventive Care Services

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

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

of the individual, and as determined appropriate by the Administrator's clinical coverage guidelines. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Some examples of Preventive Care Covered Services are:

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

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

  These include, but are not limited to:

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

10. Poliovirus vaccine.

- Screening examinations:

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

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

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

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

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

Surgical Services

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

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

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

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

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

Covered Surgical Services include, but are not limited to:

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

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

Reconstructive Services

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

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

Mastectomy Notice

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

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

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

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

Morbid Obesity Treatment Services

Covered Services include surgical treatment of morbid obesity:

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

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

- save the life of the Member; or

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

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

"Morbid obesity" means:

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

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

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

Sterilization

Sterilization is a Covered Service.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

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

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

Therapy Services

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

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

Physical Medicine Therapy Services

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

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

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

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

Other Therapy Services

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

Physical Medicine and Rehabilitation Services

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

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

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

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

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

Human Organ and Tissue Transplant Services

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

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

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

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

Covered Transplant Procedure

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

Transplant Benefit Period

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

Prior Approval and Precertification

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

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

Transportation, Meals and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator, on behalf of the Employer, when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility, lodging and meals for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. The Member must

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

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

Prescription Drug Benefits

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

Pharmacy Benefits Manager

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

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

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

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

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

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

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

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

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

Step Therapy

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

Specialty Pharmacy Network

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

"Specialty Drugs" are Prescription Legend Drugs which:

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

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

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

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

Covered Prescription Drug Benefits

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

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

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

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

Deductible/Coinsurance/Copayment

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

Days Supply

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

Tiers

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

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

Special Programs

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

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

Half-Tablet Program

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

Payment of Benefits

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

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

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

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

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

How to Obtain Prescription Drug Benefits

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

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

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

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

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

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

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

NON COVERED SERVICES/EXCLUSIONS

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

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

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

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

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

  The Plan will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:
  - cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
  - has been determined by the FDA to be contraindicated for the specific use; or
  - is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
  - is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
  - is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety,

toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

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

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

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

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

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

ELIGIBILITY AND ENROLLMENT

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

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

Eligibility

(1) All active full-time (37.5 hours per week) employees and their eligible "dependents".
(2) All appointed or elected officials and their eligible "dependents".
(3) Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.
(4) "Dependent" means:
   a) Spouse of an employee;
   b) Any unmarried dependent children, step-children, foster children, legally adopted children of the employee or Spouse, or children who reside in the employee's home for whom the employee or Spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "Dependent" until marriage or the end of the Calendar Year in which he/she attains age 19/23.
      In the event a child who is a "Dependent" as defined herein, is both:
      1. incapable of self-sustaining employment by reason of mental or physical disability, and
      2. is chiefly dependent upon the employee for support and maintenance;
      prior to age 19, such child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "Dependent" will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The Plan requires annual documentation from a physician after the child's attainment of the limiting age.
(5) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Legislator" who meets the following:
   a) Is no longer a member of the General Assembly;
   b) Who served as a legislator for at least 10 years.
      A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's Spouse covered under the health insurance program. In

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

1. The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the date of the legislator's death;
2. The surviving Spouse files a written request for insurance coverage with the employer;
3. The surviving Spouse pays an amount equal to the employer's and employee's Premium for the group health coverage for an active employee.

The eligibility of the retired legislator's Spouse, or a surviving Spouse of a legislator for group health coverage is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. The Spouse's eligibility ends on the earliest of the following:

1. When the employer terminates the health coverage program;
2. The date of the Spouse's remarriage;

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

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

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

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

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

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

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

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

iii. Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement;

(9) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:
   a) Retirement date is after June 30, 1990;
   b) Will have reached the age of sixty-two (62) on or before retirement date;
   c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;
   d) Who has at least eight (8) years of service credit as a participant in the Judge's retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge's retirement.

(10) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:
   a) Who is a retired participant under the Prosecuting Attorney's Retirement fund;
   b) Whose retirement date is after January 1, 1990;
   c) Who is at least sixty-two (62) years of age;
   d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
   e) Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.

(11) Retirees eligible under subsections 6 - 10 must file a written request for the coverage within ninety (90) days after retirement. The Spouse's subsequent eligibility to continue insurance under the surviving Spouse's eligibility end on the earliest of the following:
   a) Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the Spouse would be eligible to remain covered until the end of the maximum period under COBRA;
   b) When the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
   c) The end of the month following remarriage; or
   d) As otherwise provided in I.C. 5-10-8-8(g).

(12) Employee on a leave of absence for ninety (90) days or less and out of pay status

(13) An employee on family leave

(14) Retirees eligible under IC 5-10-12.

(15) A former legislator, dependent, or Spouse as defined and pursuant to the conditions set forth in IC 5-10-8-8.2.

(16) All active and retired full-time and part-time employees, elected or appointed officers and officials of a local unit of government that elect to provide health coverage under this plan. A local unit of government is defined as follows:
   a) A city, town, county, township, public library, or school corporation
   b) Any board, commission, department, division, authority, institution, establishment, facility, or governmental unit under the supervision of either the state or a city, town, county, township, public library, or school corporation, having a payroll in relation to persons it immediately employs, even if it is not a separate taxing unit.

(17) As otherwise provided by Act of the Indiana General Assembly.

Effective Date of Your Coverage

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

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

Newborn Infant Coverage

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

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:

    a) The date of placement for the purpose of adoption; or
    b) The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;

2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or

3. Continues unless required action as described below is not taken.

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

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

Federal Laws Related to Your Coverage

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

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

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

CHANGES IN COVERAGE: TERMINATION, CONTINUATION & CONVERSION

Termination

Individual Termination

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

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

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another group health Plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. Certifications may be requested within 24 months of losing coverage. If you have any questions, contact the customer service telephone number listed on the back of your Identification Card.

Continuation

Federal Continuation of Coverage (COBRA)

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

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

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Employer's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Employer's health plan is lost because of the qualifying event. Under the Employer's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Employer for Fee payment requirements.

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

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

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

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

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

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

If Your Employer Offers Retirement Coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Employer's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also

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

When is COBRA Coverage Available

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided

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

How Long Will Continuation Coverage Last?

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

How Can You Extend The Length of COBRA Continuation Coverage?

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

- **Disability**

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

- **Second Qualifying Event**

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

Trade Act of 1974

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

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

Premiums and the End of COBRA Coverage

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

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

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

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

If You Have Questions

Questions concerning your Employer's health plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Due To Military Service

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

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

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

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

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

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

Family and Medical Leave Act of 1993

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

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

HOW TO OBTAIN COVERED SERVICES

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

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

Network Services and Benefits

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

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

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

For services rendered by Network Providers:

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

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

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

Non-Network Services

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

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

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

Relationship of Parties (Plan - Network Providers)

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

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

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

Not Liable for Provider Acts or Omissions

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

Identification Card

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

CLAIMS PAYMENT

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

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

How Benefits Are Paid

Maximum Allowable Amount

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

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

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

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

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

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

Member Share of Cost

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

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

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

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

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

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

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

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the plan’s Maximum Allowable Amount. **If services are performed by Non Network Providers,** then you are responsible for

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

Payment of Benefits

You authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

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

Notice of Claim

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

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

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

Time Benefits Payable

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

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

Claim Forms

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

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

Member's Cooperation

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

Explanation of Benefits (EOB)

After you receive medical care, you will generally receive an explanation of benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from the Plan to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible (if any).
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

BlueCard Program

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

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

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

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

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

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

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

HEALTH CARE MANAGEMENT

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

If you have any questions regarding the information contained in this section, you may call the Precertification telephone number on the back of your Identification Card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Physician must notify the Administrator within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

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

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

Most Network Providers know which services require Precertification and will obtain any required Precertification or request a Predetermination if they feel it is necessary. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. The ordering Provider, facility or attending Physician will contact the Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Administrator will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services provided by a Network Provider	**Services provided by a BlueCard/Non-Network/Non-Participating Provider**
Provider	• Member is responsible for Precertification. • Member is financially responsible for service and/or setting that are/is not covered under the Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative.

The Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventative care clinical coverage guidelines, to assist in making Medical Necessity decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. The Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Benefit Booklet and the Administrative Services Agreement take precedence over these guidelines.

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

Request Categories:

Urgent – a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.
Prospective – a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
Concurrent - a request for Precertification or Predetermination that is conducted during the course of treatment or admission.
Retrospective - a request for Precertification that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, the Administrator will abide by state regulations.

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

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	2 business days from the receipt of the request
Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours or 2 business days from the receipt of request whichever is less
Concurrent Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent Non-Urgent	15 calendar days from the receipt of the request

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

The Administrator will provide notification of its decision in accordance with state and federal regulations. Notification may be given by the following methods:

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

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

1. you must be eligible for benefits;
2. Premiums must be paid for the time period that services are rendered;
3. the service or surgery must be a covered benefit under the Plan;
4. the service cannot be subject to an Exclusion under the plan, including but not limited to a Pre-Existing Condition limitation or Exclusion; and
5. you must not have exceeded any applicable limits under the Plan.

CARE MANAGEMENT

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

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

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

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

Value-Added Programs

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

MEMBER GRIEVANCES

Grievances

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

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

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

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

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

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

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

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

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

Appeals

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

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

Expedited Review

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

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

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

External Grievance

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

- Your Appeal is regarding:

1. an adverse determination of appropriateness; or
2. an adverse determination of Medical Necessity; or
3. a determination that a proposed service is Experimental/Investigational made by the Administrator or an agent regarding a service proposed by the treating Physician; and

- You or your representative request the External Grievance in writing within forty-five (45) days after You are notified of the Appeal panel's decision concerning your Appeal; and
- The service is not specifically excluded in this Benefit Booklet.

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

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

Grievance/Appeal Filing Time Limit

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

Grievances and Appeals by Members of ERISA Plans

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

GENERAL PROVISIONS

Entire Contract

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

Form or Content of Benefit Booklet

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

Disagreement with Recommended Treatment

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

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

Circumstances Beyond the Control of the Plan

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

Protected Health Information Under HIPAA

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

Coordination Of Benefits

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

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

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

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

Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowable Amount.

COB DEFINITIONS

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

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

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

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

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an

Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.

6. The amount that is subject to the Primary high-deductible health plan’s deductible, if the Administrator has been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

7. Any amounts incurred or claims made under the Prescription Drug program of this Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes

coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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

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

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

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;

   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or

   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

     - The Plan covering the Custodial parent;

     - The Plan covering the spouse of the Custodial parent;

     - The Plan covering the non-custodial parent; and then

     - The Plan covering the spouse of the non-custodial parent.

3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

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

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by state or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

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

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

EFFECT ON THIS PLAN'S BENEFITS

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than should have paid under this COB provision, the Administrator, on behalf of the Employer, may recover the excess from one or more of the persons:

1. The Plan has paid or for whom the Plan has paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

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

Medicare

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

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

Physical Examination

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

Worker's Compensation

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

Other Government Programs

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

Subrogation and Reimbursement

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

Subrogation

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

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

Reimbursement

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

- You must reimburse the Plan to the extent of benefits the Plan paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Plan shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
    2. you fail to cooperate.

- In the event that you fail to disclose to the Plan the amount of your settlement, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan would not have any obligation to pay the Provider.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights.
- You must not do anything to prejudice the Plan's rights.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

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

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

Relationship of Parties (Employer-Member Plan)

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

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

Anthem Blue Cross and Blue Shield Note

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

D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Conformity with Law

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

Clerical Error

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

Policies and Procedures

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

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

Waiver

No agent or other person, except an authorized officer of the Employer, has able to disregard any conditions or restrictions contained in this Benefit Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion

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

Reservation of Discretionary Authority

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

DEFINITIONS

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

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

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

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

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

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

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Administrator, on behalf of the Employer, to be paid at the Network level.

Behavioral Health Conditions –

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Experimental/Investigative – Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Administrator, on

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medically Necessary/ Medical Necessity - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Administrator to be:

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

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

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

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

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

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

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

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

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

New FDA Approved Drug Product or Technology does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Alcoholism Treatment Facility -** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility –** A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:

  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
  2. Surgery
  3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility -** A facility, with an organized staff of Physicians, that:

  1. Is licensed as such, where required;
  2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  4. Does not provide Inpatient accommodations; and
  5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Certified Advance Registered Nurse Practitioner**

- **Certified Nurse Midwife**

- **Certified Registered Nurse Anesthetist**

- **Certified Surgical Assistant**

- **Day Hospital -** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Drug Abuse Treatment Facility -** A facility which provides detoxification and/or rehabilitation treatment for drug abuse.

- **Home Health Care Agency -** A facility, licensed in the state in which it is located, which:

  – Provides skilled nursing and other services on a visiting basis in the Member's home; and
  – Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- **Home Infusion Facility -** A facility which provides a combination of:

  1. Skilled nursing services
  2. Prescription Drugs
  3. Medical supplies and appliances

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

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. Provides room and board and nursing care for its patients;
  2. Has a staff with one or more Physicians available at all times;
  3. Provides 24 hour nursing service;
  4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
  5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

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

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

- **Laboratory (Clinical)**

- **Licensed Practical Nurse**

- **Licensed Professional Counselors**

- **Occupational Therapist**

- **Outpatient Psychiatric Facility -** A facility which mainly provides Diagnostic and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.

- **Pharmacy** - An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist**

- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).

- **Psychiatric Hospital -** A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Psychologist -** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse First Assistant**

- **Registered Nurse**

- **Registered Nurse Practitioner**

- **Regulated Physician's Assistant**

- **Rehabilitation Hospital -** A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the

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

- **Respiratory Therapist (Certified)**

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

- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. provides care supervised by a Physician;
  3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
  4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
  5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.

- **Speech Therapist**

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center -** A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

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

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

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

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

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

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

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

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

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

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

FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENTS, OR BILLINGS

CUSTOMER SERVICE NUMBER

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

Medical Questions –1-877-814-9709

PRECERTIFICATION

1-877-814-4803

MENTAL HEALTH OR SUBSTANCE ABUSE PROGRAM

1-800-223-7723

EMPLOYEE ASSISTANCE PROGRAM

1-800-223-7723

PHARMACY NETWORK

1-800-662-0210

PLEASE HAVE YOUR IDENTIFICATION NUMBER READY WHEN YOU CALL

ADVANTAGE HEALTH SOLUTIONS, INC.

CERTIFICATE OF COVERAGE

***Group*:**			
Policy #:		***Group Contract* Eff:**	**01/01/2009**
***Member* ID #: As Shown on ID Card**			
***Policy maximum*:**	**Unlimited** **See definition**		

***Deductible*:**

Except where indicated, benefits are subject to a $250 *deductible* per member, per calendar year.

Covered services for outpatient prescription drugs are subject to a: $100 *deductible per single and $200 deductible per family* on all Brand Name Drugs per member per calendar year this excludes Diabetic Supplies.

All *Covered Service* are subject to the *Policy maximum* applicable to each *member*.

New Hire Eligibility:

New hires shall become effective on the first (1st) of the month following 45 days of employment.

Dependent Age Limit:

Unmarried children are eligible to the last day of the year in which the child reaches age 24. Any Young Adult child age 19 up to the day of the 24th birthday., regardless of marital status, is eligible for coverage under the Young Adult Rider if the Young Adult is: (1) the natural or adopted children of the subscriber; or (2) the stepchild, grandchild, or other blood relative of the subscriber and the subscriber pays more than 50% of the Young Adult's total support; or (3) the subscriber is the Young Adult's legal guardian and the subscriber pays more than 50% of the Young Adult's total support.

IMPORTANT CONTACTS

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

Your PCP: _____
Address: _____
Telephone: _____

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

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

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

ADVANTAGE Health Solutions, Inc. SM **(*ADVANTAGE*)** :

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

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

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

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

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

Web site
www.*advantage*plan.com

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

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SECTION 1: WELCOME TO *ADVANTAGE*

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

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

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

Our Company

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

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

Our Mission

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

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

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

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

ALWAYS REMEMBER. . .

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

YOUR RIGHTS AND RESPONSIBILITIES

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

***You* Have the Right…**

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

***You* Have the Responsibility . . .**

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

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

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

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

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

How do I schedule an appointment with my *PCP*?
Call the *PCP*'s office to schedule an appointment. Always identify *your*self as an *ADVANTAGE member*.

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

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

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

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

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

What do I do if I need medical services after my *PCP*'s normal office hours?
If *you* must reach *your PCP* after normal office hours, *you* may do so by calling the *PCP*'s telephone number listed on *your ID card*. *You* may be uncertain if *you* should call the *PCP* immediately or wait until normal office hours. Remember, routine questions and problems should be handled during normal business hours. Examples of routine questions or problems may include:
- Scheduling appointment for physical exam
- Requesting information regarding *your* child's vaccinations
- Non-*emergency* conditions, such as:
  - Cold or flu symptoms
  - Muscle sprain
  - Skin rash
  - Earache
  - Other symptoms or conditions that do not require immediate medical treatment

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

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

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

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

SECTION 2A – SPECIALTY CARE SERVICES:

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

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

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

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

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

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

IDENTIFICATION CARD

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

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

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

COVERAGE INFORMATION

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

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

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

Who can be covered under dependent *coverage*?

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

  If a *dependent* of the *subscriber* or *spouse* who attained the limiting age while covered under another health care policy meets the criteria specified above, the *dependent* is an *eligible dependent* for enrollment so long as no break in *coverage* longer than 63 days has occurred immediately prior to enrollment. *ADVANTAGE* will require proof of disability as described above.
- Court-Ordered *Coverage*: A court or administrative agency of competent jurisdiction orders *you* or *your* family members to provide health *coverage* for a child under age 18. The child may be enrolled by his custodial parent; his non-custodial parent; the office of Medicaid Policy and Planning; or a Title IV-D agency. The date of status change is the date the order is issued.

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

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

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

What do I do when there is a change in my family status?
In order to avoid problems for proper claims payments, it is very important that *you* let *your Group* know of any and all changes in *your* family status. Examples of family status changes include:

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

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

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

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

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

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

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

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

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

The term "*late enrollee*" does not include:

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

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

Special Enrollment Periods

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

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

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

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

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

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

Other Rules of Enrollment

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

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

SECTION 4: *COVERED SERVICES* – BENEFITS

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

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

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

Prior *Authorization*

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

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

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

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
ADVANTAGE ensures *you* can obtain behavioral health services in a timely manner. The *ADVANTAGE* appointment standards for behavioral health care are: • Routine office visits within 10 business days • Initial non-urgent appointments within 10 business days • Urgent appointments within 24 hours • *Emergency* Care is immediate		
Mental Health Services *Option*:		
• *Inpatient psychiatric hospital* services, including evaluation and treatment in a psychiatric day treatment facility, when *medically necessary*, ordered by *your* designated behavioral health *provider* for mental health services and *authorized* by the *behavioral health network*. Limited to 2 *copayments* per *calendar* year.	$250 *copayment*	
• *Outpatient visits* will be provided when *medically necessary* and ordered by *your* designated behavioral health *provider*. *Copayment* applies to both individual therapy and Group therapy sessions.	$35 *copayment*	
• *Partial hospitalizations* Two (2) days of *partial hospitalization* count as one (1) day of *inpatient* services.	$125 *copayment*	
Substance Abuse Option:		
Covered services are provided without limits when treatment of substance abuse and chemical dependency services are required in the treatment of mental *illness*.		
Detoxification for alcohol or other drug addiction is covered on an *inpatient* and/or *outpatient* basis, whichever is determined to be *medically necessary*. To be covered, services must be *authorized* by *your* designated *behavioral health network*. *Covered services* are subject to the limitations listed below: • The treatment setting, e.g., *inpatient, outpatient*, residential or transitional, for the treatment of alcohol or other drug dependency shall be determined by *your behavioral health network* designated by *ADVANTAGE* in accordance with *medical necessity*. • The number of rehabilitation days covered represents the days per *Contract year* of *inpatient* or intensive *outpatient* daycare. Depending on the level of care *medically necessary* for the treatment of alcohol or other drug dependency, covered *inpatient* days will be counted against the rehabilitation day limitations as follows: – One (1*) inpatient* day = one (1) residential day – One (1) extended day *outpatient* treatment = one half *inpatient* day		
• Uniformed *Inpatient* Substance Abuse Services: Limited to 30 days per *calendar* year. Additional 30 days available at 50% *coinsurance*. Lifetime maximum of 2 detoxification admissions.	$250 *copayment*	
• Non-Uniformed *Inpatient* Substance Abuse Services: Limited to 14 days per *calendar* year. Lifetime maximum of 2 detoxification admissions.	$250 *copayment*	
• *Outpatient* Substance Abuse Services: Limited to 20 visits per *calendar* year.		50% *coinsurance*
• *Partial hospitalizations*: Two (2) days of *partial hospitalization* count as one (1) day of *inpatient* services.	$125 *copayment*	

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Corrective Appliances and Prosthetics		
Corrective appliances and prosthetics must be *medically necessary* and used to restore function or to replace body parts. They must be provided with a *proper referral* and as prescribed by the *participating physician*. Examples of corrective appliances include, but are not limited to • Pacemakers • Hemodialysis equipment • Breast prostheses • Prosthetic limbs • Back braces • One pair of eyeglass lenses following cataract surgery not to include tinting, scratch-proofing or transitioning. • Ostomy supplies *Covered services* include the purchase, replacement or adjustment of artificial limbs or eyes, when required due to a change in *your* physical condition or body size due to normal growth.		50% *coinsurance*

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

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

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Dental – Limited *Covered services*		
Medical services related to *injury* to sound and natural teeth when *injury* is reported immediately, and treatment must be sought with proper referral to a *participating provider* within a 72-hour period. *Injury* must be traumatic (an *injury* to living tissue caused by an extrinsic agent) or caused by the force of an external object striking the tooth. After *emergency* treatment, follow-up care must be obtained from a *participating provider* upon a *proper referral* from the *PCP* and initiated within sixty (60) days of the *injury*. All treatment must be completed within one year from the initiation of treatment and accident must have been incurred on or after the *effective date of coverage*	$35 *copayment*	

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

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

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

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

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

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

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Diabetes Self Management Training		
Covered services are limited to • *Physician* authorized visit(s) after receiving a diagnosis of diabetes • *Physician* authorized visit(s) after receiving a diagnosis that represents a significant change in *your* symptoms or condition and there is a *medically necessary* change in *your* self-management • *Physician* authorized visit(s) for re-education or refresher training		
Diabetes self-management training	No *copayment*	No *coinsurance*

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Durable medical equipment* (*DME*)**		
Rental or purchase of *DME*, including all durable and non-durable supplies required to operate the *DME* and are integral to the *DME* set-up. The following *covered services* apply if there is a *proper referral and:* • When *medically necessary* • When equipment can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of *illness* or *injury* and is suitable for use in *your* home. Examples of *DME* include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, *hospital* beds, monitoring devices, oxygen-breathing apparatus, and insulin pumps. • Training in the use of any *medically necessary* covered *DME* is also covered, when so authorized • Rental payments apply to purchase of equipment		*50% coinsurance*

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

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

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

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Emergency services* and *Urgent care		
An *emergency service* means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to: • place an individual's health in serious jeopardy; • result in serious impairment to the individual's bodily functions; • or result in serious dysfunction of a bodily organ or part of the individual. Examples include, but are not limited to, heart attacks, strokes, poisonings, severe bleeding and convulsions.		
Emergency Room: Includes all related services *Copayment* waived if admitted	$125 *copayment*	

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

What do I do if I need follow-up care?
If *you* receive *emergency services* or *urgent care* services, *you* should contact *your participating provider*'s office within 48 hours or as soon as reasonably possible after *you* receive the services to allow *your PCP* to arrange follow up treatment.

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

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

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

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

Always remember. . .

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

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

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

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

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

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

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

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

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Home health services		
Medically necessary home health services with a *proper referral*, including: • Skilled medical services. If continuous medical or skilled nursing services are required, *ADVANTAGE* may require transfer to a *SNF* or other facility if medically appropriate and more cost effective. • Nursing care given or supervised by a *Registered nurse (RN).* • Nutritional counseling furnished or supervised by a registered dietician. • Home hospice services. • Home health aides • Medical supplies, laboratory services, drugs, and medicines prescribed by a *physician* in connection with home health care. • Medical social services. • Training of family members or significant other to provide those *home health services* that can be performed by laypersons.	$0 *copayment*	

Services are considered *covered services* only if they are not considered *custodial care* and the services are prescribed in writing by a *participating physician:*

- As *medically necessary* for the care and treatment of *your illness* or *injury* at home;
- As being in place of *inpatient hospital* care or a convalescent nursing home that would be required in the absence of such services; and
- The services are furnished to *you* while under a *participating physician's* care.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Hospital* Care (*Inpatient* and *Outpatient* Medical and Surgical)**		
Inpatient Hospital Services: *Inpatient biologic/biopharmaceutical medications* do not require additional *copayment or coinsurance*. Copayment limited to 2 inpatient admissions per calendar year.	$250 *copayment* per *admission* after deductible (waived if re-admitted within 24 hours of discharge)	
Outpatient Surgical Services: *Outpatient* surgery facility services including those diagnostic invasive procedures that may or may not require anesthesia.	$125 *copayment after deductible*	

What do I do when I need to be *hospital*ized?
Your physician will arrange *your* admission to a *hospital* in the *provider network*.

How do I select a *hospital* or *outpatient* facility?
- When *you* select a *PCP*, *you* agree to utilize the *hospitals* and facilities in *your PCP's provider network*.

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

Medically necessary professional services for surgical operations (major and minor), include but are not limited to:
- Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident occurring while a *member* (if services begin within one year of the accident);
- Replacement of diseased tissue surgically removed while a *member*;
- Treatment of a birth defect in a Dependent child;
  ADVANTAGE is a health maintenance organization responsible for arranging for the provision of *covered services* under *your* benefits. Federal law requires health *carriers* that provide medical and surgical benefits for mastectomies to also cover reconstructive surgery and other related services following a mastectomy. Under the law, if a *member* has a mastectomy and, in consultation with the *physician*, elects to have reconstructive surgery, the *covered services* would include:
  - Reconstruction of the breast upon which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and physical complications at all stages of mastectomy, including lymphedemas.
- The manner of treatment for any given patient is to be decided in consultation with the attending *physician* and patient. The law permits *copayments, coinsurance and deductibles* to apply.

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

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Maternity Care		
• Professional obstetrical care, including prenatal visits, antepartum care, and one postpartum visit per pregnancy term regardless of date of conception. Including *physician services*, laboratory and x-ray services as *medically necessary* and appropriate.		
One time *copayment* of:	$20 initial visit (*PCP*)	
One time *copayment* of:	$35 initial visit (*SCP*)	

Please refer to "Hospital Care" for inpatient benefits

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

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

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

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*

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

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

What are the *non-covered services*?
Non-durable supplies and/or convenience items are not covered.

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Morbid Obesity *Option*		
Morbid Obesity means: • A body mass index of at least thirty-five (35) kilograms per meter squared, with co-morbidity coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or • A body mass index or at least forty (40) kilograms per meter squared without co-morbidity.		
Non-surgical Treatment for Morbid Obesity		
As an alternative to surgical treatment for *morbid obesity*, *ADVANTAGE* will pay for enrollment in an in-network *physician*-supervised weight loss treatment program when referred by your physician and authorized by *ADVANTAGE*.	Enrollment fees in excess of $50 after $35 *copayment* per visit. Maximum of 6 visits per *calendar* year.	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Newborn Examinations		
Newborn examinations are covered under maternity care, or *hospital* care, or *physician* office visits. Newborn examinations include the detection of: • *Inherited Metabolic Disease* includes services for *medical food* and *low protein modified food products*, (not subject to *copayment*, regardless of supplier) as defined in the Glossary of Terms. • Hypothyroidism • Hemoglobin paths, including sickle cell anemia • Galactosemia • Maple Syrup Urine Disease	No additional *copayment*	

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

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

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Physician* Services – Office visits for the treatment of *illness* or *injury		
Office Visit Services:		
• *Primary care physician* Office Visit	$20 *copayment* per office visit	
• Specialty and Referral *Physician* Office Visit	$35 *copayment* per office visit	

- Office visits, services and supplies for the determination and/or treatment of *illness* or *injury*. These services include medical consultations, and procedures performed in the *physician*'s office, *second opinion* consultations, and specialist treatment services.
- Allergy Testing
- Diabetes self-management training
- Maternity care – refer to Maternity Care benefit

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Physician* Services for wellness and preventive services** The following services will be included in the office visit *copayment* when services are performed in the *physician* office. Services performed outside of the *physician* office will not have a *copayment*.	Included in the *physician* office visit *copayment*	

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

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

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

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

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

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

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

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

PHARMACY SERVICES

Outpatient Prescription Drug *Option*

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

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

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

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

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

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

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

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

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

Is prior *authorization* required for *outpatient* prescription drugs?

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

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

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

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

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

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

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

A drug not approved by the FDA may be prescribed if one of the following conditions is met:
- the drug is recognized for treatment of the indication in at least one (1) standard referenced compendium; or
- the drug is recommenced for that particular type of cancer and found safe and effective in informal clinical studies; the results which are published in the United States or Great Britain.

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

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

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

Where do I get my prescriptions filled?

Retail Pharmacy Locations

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

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

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

Mail Order Program

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

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

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

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

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

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Skilled nursing facility*/*hospice facility*:**		
Limited to 100 days per "*Benefit period*" as defined by Medicare and in this *Certificate*. Day limits do not apply to hospice.		
*Skilled nursing facility (SNF)/*Extended Care Services, *inpatient* hospice:	$0 *copayment*	

Covered services when *medically necessary* with a *proper referral* include:

- Semi-private room; private room provided when *medically necessary*.
- Drugs, biologicals, medical social services, short term physical, speech, occupational therapies (subject to limitations listed in the Short-term Therapies indicated below) and other services generally provided by *skilled nursing facilities*.
- *Hospice care* provided if *you* are *terminally ill*, in accordance with a treatment plan developed before *your* admission to the *hospice care* program. Treatment plan must include a statement from the *physician* documenting that life expectancy is six months or less.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Therapies -- Short-Term:		
Short-Term Therapies are limited to a combined 60 visits per each distinct condition or episode, or as authorized through a medical management regimen	$35 *copayment*	

Short-term Physical Therapy
Short-term physical therapy – covered with *prior authorization* for a condition that the *physician* believes is subject to continuing improvement.

Short-term Speech and Occupational Therapy
Short-term speech or occupational therapy – services are covered with *prior authorization*, if provided to correct an impairment due to *injury* or *illness*; or a congenital defect.

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

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

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

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

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

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

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

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

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

- voluntary sterilization or reversal of sterilization;
- birth control drugs, supplies, or devices; however, *you* are entitled to access *ADVANTAGE's* discount for such drugs through a *contracting pharmacy;*
- use of a surrogate for any reason

56. Hearing aids, Hearing therapy, or cochlear implants and their fitting

57. Audiometric exams for the purpose of hearing aids.

58. Treatment of temporomandibular joint (TMJ) disorder;

59. Extensive long-term neuromuscular rehabilitation, i.e., physical, speech or occupational therapy is excluded. Rehabilitation that the *physician* reasonably believes will require in excess of 60 days per each distinct condition or episode, beginning with the first rehabilitation treatment for that condition, will be considered "long-term" and is not covered. (When *you* undergo a rehabilitative treatment for a specific and distinct condition, that visit constitutes one treatment). *ADVANTAGE* reserves the right to extend *covered services* through a formal medical management regimen.

60. Personal comfort items, including but not limited to services and supplies not directly related to *your* care, such as guest meals and accommodations, private room (unless *medically necessary*), personal hygiene products, telephone charges, travel expenses (other than approved *ambulance* services as provided in the basic health services), take-home supplies including prescription drugs and similar items;

61. Service obtained by a *member* from *physicians, hospitals* or other *providers* not associated with *ADVANTAGE*, either within the *service area* or outside the *service area* (except *emergency services* or upon proper referral by a *participating physician*);

62. Recreational or educational therapy;

63. Treatment and testing for adolescents and children, which are state mandated services by or of the school system, unless therapy is deemed *medically necessary* by a *participating provider*;

64. Court ordered therapy, unless appropriate, *medically necessary*, and *authorized* by *your participating behavioral health provider*;

65. Vocational therapy, including work hardening programs;

66. Newborn deliveries performed by a midwife in the home and any charges, including but not limited to supplies and equipment as a result of such deliveries.

67. Treatment or services related to *pre-existing medical condition* which are incurred during the *pre-existing medical condition exclusion period* as defined in this *Certificate*

68. Growth Hormones and related products;

69. Services and supplies for the treatment of alopecia and/or alopecia areata;

70. Corrective appliances and artificial aids which are not necessary for the restoration, function, or replacement of a body part; non-durable appliances;

71. Speech therapy due to a delay in speech development;

72. Common first aid supplies;

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

74. Non-durable supplies and/or convenience items which are not required to operate a durable medical device and are not an integral part of the *DME* set-up;

75. Non-durable medical supplies for use outside the *hospital* or *physician* office;

76. Surgical treatment of *morbid obesity*;

77. Maternity services when *member* is acting as a surrogate mother.

78. Treatment or services related to *pre-existing medical conditions* which are incurred during the *pre-existing medical exclusion period* as defined in this *Certificate.*

79. Services and supplies provided after *Policy maximum* has been exceeded by the *member.*

80. Medical care for a *preexisting medical condition* of a *Young Adult* until six (6) months after the effective date of the *Young Adult's* coverage with *ADVANTAGE*. This *preexisting medical condition* limitation period will be reduced by the number of days of *prior creditable coverage* the *Young Adult* has at the time of enrollment. The *preexisting medical condition* limitation does not apply to:
    (1) a *dependent* who, on the date he or she is otherwise eligible for coverage, is adopted by, or placed for adoption with, the *subscriber;* or
    (2) a newly born *dependent* Child of the *subscriber*,
    if the child, as of the last day of the 30 day period beginning with the date or birth or date of adoption or placement for adoption, is covered under *creditable coverage*.

Other Limitations

Cost Effectiveness:
ADVANTAGE will not pay the cost of any *inpatient* or other care which could have been provided by a *participating physician's* office, in the *outpatient* department of a *hospital*, or in another less costly location without adversely affecting the patient's condition or the quality of medical care rendered, unless the UM Committee has determined the care to be *medically necessary*. Nor will *ADVANTAGE* pay the cost of any service or article which is significantly more expensive than an available alternative, unless the UM Committee has determined the more expensive service or article has been demonstrated to be of significantly greater therapeutic value than the other, less expensive, alternative.
Circumstances Beyond *ADVANTAGE's* Control:
Neither, *ADVANTAGE*, nor *participating hospitals*, nor any *participating provider* shall have any liability or obligation for delay or failure to provide health care services:

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

- Due to lack of available facilities or personnel if caused by disaster or epidemic.

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

SECTION 6: COMPLAINTS, *GRIEVANCE*S AND APPEALS

*GRIEVANCE*S – LEVEL 1

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

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

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

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

*Grievance*s will be resolved according to the following time frames:

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

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

APPEALS LEVEL 2

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

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

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

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

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

Appeals will be resolved according to the following time frames:

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

- Post-service appeals: A post-service *grievance* or appeal is a request to change an adverse determination for care or services that have already been received by the *member*. *ADVANTAGE* resolves post-service appeals within 30 *calendar* days from receipt of the request.

EXPEDITED *GRIEVANCE*S AND APPEALS

Expedited *grievance*s and appeals (Level I and Level II):

ADVANTAGE offers the *member* an expedited appeal for any *urgent care* request. *Urgent care* involves conditions which: "Could seriously jeopardize the life or health of the *member* or the ability of the *member* to regain maximum function, based on a prudent layperson's judgment or in the opinion of a *physician* with knowledge of the *member's* medical condition would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request."

ADVANTAGE must make the expedited *grievance* or appeal decision as expeditiously as the medical condition requires, but no later than 72 hours after the request at each level of review (Level I and Level II). An expedited review begins when a *member*, a representative of the *member*, or a practitioner acting on behalf of the *member* requests an expedited appeal either verbally, by facsimile, in writing or by any means of electronic communication. *ADVANTAGE* grants an expedited review to all requests concerning admissions, continued stay or other health care services for a *member* who has received *emergency services* but has not been discharged from the facility.

ADDITIONAL INFORMATION

Right to Receive Information

For any level of appeal, *you* are entitled to receive, upon request, reasonable access and copies of all documents relevant to the *grievance* or appeal. Relevant documents include documents or records relied upon in making the decision and documents and records submitted in the course of making the decision. *You* are entitled to receive, upon request, a copy of the actual benefit provision, guideline, protocol or similar criterion on which the decision was based.

Designating a Representative

A *member* may designate a representative to file a *grievance* for the *member* and to represent the *member* in the resolution and/or appeal of any *grievance* or appeal. *You* may need to sign a release in order to allow us to discuss *your* situation with *your* representative.

External Review

If *you* are dissatisfied with our decision of the second-level review, *you* may have the option of requesting an external review by an Independent Review Organization certified by the Indiana Department of Insurance. If *you* choose to request an external review of *your* appeal, send a notice in writing within 180 *calendar* days of receipt of the second-level decision. Per Indiana Code IC 27-13-10.1-1, *you* may request an external review for the resolution of *grievance*s regarding:

1. an adverse utilization determination
2. an adverse determination of medical necessity: or
3. a determination that a proposed service is *experimental* or *investigational* made by a health maintenance organization or an agent of a health maintenance organization regarding a service proposed by a treating *physician*.

Please address *your* request for an external review to the Appeals Specialist at the address listed on page 2 of this *Certificate*:

Under the external review process, the Independent Review Organization will make a determination within 15 working days of *your* request, or for expedited requests, within 72 hours of receipt of *your* request. *You* may provide any requested information to the Independent Review Organization or authorize our release of information to the Independent Review Organization

You may be required to pay up to $25.00 of the costs for the external review. *You* may not file more than one external review request for each *grievance*. If *you* have the right to external review under Medicare, *you* may not request external review through the plan.

QUESTIONS AND CONCERNS

Your satisfaction is very important to us. We have set up the *Grievance* Procedure to help ensure that any problem with any aspect of this Plan is addressed in a fair and timely manner. We fully expect to provide a fair settlement for every valid *grievance* in a timely fashion. However, if *you* feel *you* (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint *you* have been unable to resolve with *your* insurer *you* may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: (800) 622-4461 or
Indianapolis area: (317) 232-2395

Complaints can also be filed electronically at www.in.gov/idoi

You may also have remedies available to *you* through The Department of Labor and ERISA regulations.

SECTION 7: PAYMENT TO *PROVIDERS* AND CLAIMS FILING INFORMATION

Do I need to submit a claim for my in-network medical care?
No, *you* do not need to submit a claim. When *you* receive medical care from an in-*network participating provider*, including a *participating hospital*, that *participating provider* will submit all claims for *you*.

You must pay any *copayment* at the time of service. A *participating provider* may seek payment from *you* only for *deductible*s, *copayments*, *coinsurances* and for charges for *non-covered services*. Most of the time, *you* will not need to make a payment for *covered services*. After claims have been adjudicated, *your participating provider* will bill *you* for any services that are subject to *coinsurance*.

Do I need to submit a claim form for out-of-network care?
When services are provided by a *non-participating provider* or in the case of *emergency* medical services, *you* may need to pay the *provider* and then submit a claim. A *non-participating provider* may require *you* to pay any charges that are above the *Maximum allowable amount*. Please contact Member Services at the number shown on the Important Numbers page of this *Certificate*. They will provide instructions and a mailing address.

When will my claim be paid?
Claims will be paid within 45-days when filed on paper and 30 days when filed electronically after *ADVANTAGE* receives all information required to determine liability under the terms of this *Certificate.* If *ADVANTAGE* denies all or part *your* claim, *ADVANTAGE* (or *ADVANTAGE*'s designated agent) will provide *you* with a written notice that includes the reason(s) for denial.

When do I need to submit my claim?
A claim for a *participating provider* must be submitted within 90-days after the date the services are received or the date *you* made payment.

However, failure to give notice within the 90-day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within the period and that notice was given as soon as was reasonably possible.

Claims for *covered services* rendered by *providers* not *participating* with *ADVANTAGE* should be sent to the mailing address indicated in the "Network Administrator" section of *your ID card*. If a charge is made to *you* for any service that is reimbursable under the *Certificate*, written proof of such charge must be submitted to *ADVANTAGE* within 45-days after delivery of the service and must include an itemized statement plus diagnosis. Failure to furnish this documentation within the specific period will invalidate or reduce the claim unless, for a good reason, it was not possible to submit the claim within the specific period, and proof is produced on a timely basis as soon as possible thereafter.

ADVANTAGE will ordinarily make payment for *covered services* directly to the person or institution providing the services. However, if *you* furnish evidence that payment has been made by the *subscriber* to such person or institution for *covered services*, reimbursement will be made to the *subscriber* after deducting any payment made by *ADVANTAGE* before receipt of such evidence.

ADVANTAGE, at *ADVANTAGE's* own expense, shall have the right and opportunity to examine the *member* whose sickness or *injury* is the basis of a claim as often as it may reasonably require during the claim period.

Claims disputed by *you* will be resolved by the procedures set forth in this *Certificate*.

What do I do if I receive a bill for in-network medical care?
If *you* should receive a bill for in-network medical services for which *you* are not responsible, please call Member Services at the number shown on the Important Numbers page of this *Certificate*.

SECTION 8: *COORDINATION OF BENEFITS* WITH OTHER *COVERAGE*

This *coordination of benefits* (*COB*) provision applies when a person has health care *coverage* under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determines which *plan* will pay as the primary plan. The primary *plan* that pays first pays without regard to the possibility that another *plan* may cover some expenses. A secondary *plan* pays after the primary *plan* and may reduce the benefits it pays so that payments from all *Group plans* do not exceed 100% of the total allowable expense.

Definitions

- A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated *coverage* for members for a *Group*, the separate contracts are considered parts of the same *plan* and there is no *COB* among those separate contracts.
  (1) "Plan" includes: *Group* insurance, closed panel or other forms of *Group* or *Group*-type *coverage* (whether insured or uninsured); *hospital* indemnity benefits in excess of $100 per day; medical care components of *Group* long-term care contracts, such as skilled nursing care; medical benefits under *Group* or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  (2) "Plan" does not include: individual or family insurance; closed panel or other individual *coverage* (except for *Group*-type *coverage*); amounts of *hospital* indemnity insurance of $100 or less per day; school accident type *coverage*, benefits for non-medical components of *Group* long-term care policies; Medicare supplement policies, Medicaid policies and *coverage* under other governmental *plan*s, unless permitted by law.

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

- The order of benefit determination rules determine whether this *plan* is "primary plan" or "secondary plan" when compared to another *plan* covering the person.

  When this *plan* is primary, its benefits are determined before those of any other *plan* and without considering any other *plan*'s benefits. When this *plan* is secondary, its benefits are determined after those of another *plan* and may be reduced because of the primary *plan*'s benefits.

- "Allowable expense" means a health care service or expense, including *deductible*s and *copayment*s that are covered at least in part by any of the *plan*s covering the person. When a *plan* provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plan*s is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expense*s:
  (1) If a covered person is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the *plan*s routinely provides *coverage* for *hospital* private rooms) is not an *allowable expense*.
  (2) If a person is covered by 2 or more *plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expense*.
  (3) If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the primary *plan*'s payment arrangements shall be the *allowable expense* for all *plan*s.
  (4) The amount a benefit is reduced by the primary *plan* because a covered person does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred *provider* arrangements.

- "Claim determination period" means a *calendar year*. However, it does not include any part of a year during which a person has no *coverage* under this *plan*, or before the date this *COB* provision or a similar provision takes effect.

- "Closed panel *plan*" is a *plan* that provides health benefits to covered persons primarily in the form of services through a panel of *provider*s that have contracted with or are employed by the *plan*, and that limits or excludes benefits for services provided by other *provider*s, except in cases of emergency or referral by a panel member.

- "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the *calendar year* without regard to any temporary visitation

Order of Determination Benefits Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary *plan* pays or provides its benefits as if the secondary *plan* or *plan*s did not exist.
- A *plan* that does not contain a *coordination of benefits* provision that is consistent with this regulation is always primary. There is one exception: *coverage* that is obtained by virtue of membership in a *Group* that is designed to supplement a part of a basic package of benefits may provide that the supplementary *coverage* shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical *coverage*s that are superimposed over base *plan hospital* and surgical benefits, and insurance type *coverage*'s that are written in connection with a *closed panel plan* to provide out-of-network benefits.
- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is secondary to that other *plan*.
- The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.
  1. Non-Dependent or Dependent. The *plan* that covers the person other than as a dependent, for example as an employee, *member*, *subscriber* or retiree is primary and the *plan* that covers the person as a dependent is secondary. However, if the

person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *plan* covering the person as a dependent; and primary to the *plan* covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two *plan*s is reversed so that the *plan* covering the person as an employee, *member*, *subscriber* or retiree is secondary and the other *plan* is primary.

2. Child Covered Under More Than One *Plan*. The order of benefits when a child is covered by more than one *plan* is:
   a. The primary *plan* is the *plan* of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care *coverage*.

      If both parents have the same birthday, the *plan* that covered either of the parents longer is primary.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care *coverage* and the *plan* of that parent has actual knowledge of those terms, that *plan* is primary. This rule applies to *claim determination period*s or *plan* years commencing after the *plan* is given notice of the court decree.
   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The *plan* of the *custodial parent*;
      - The *plan* of the *spouse* of the *custodial parent*;
      - The *plan* of the non-*custodial parent*; and then
      - The *plan* of the *spouse* of the non-*custodial parent*.
3. Active or Inactive Employee. The *plan* that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other *plan* does not have this rule, and if, as a result, the *plan*s do not agree on the order of benefits, this rule is ignored. *Coverage* provided an individual as a retired worker and as a dependent of an actively working *spouse* will be determined under the rule labeled B (1).
4. Continuation *Coverage*. If a person whose *coverage* is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an employee, *member*, *subscriber* or retiree (or as that person's dependent) is primary, and the continuation *coverage* is secondary. If the other *plan* does not have this rule, and if, as a result, the *plan*s do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of *coverage*. The *plan* that covered the person as an employee, *member*, *subscriber* or retiree longer is primary.
6. If the preceding rules do not determine the primary *plan*, the *allowable expense*s shall be shared equally between the *plan*s meeting the definition of *plan* under this regulation. In addition, this *plan* will not pay more than it would have paid had it been primary.

Effect on the Benefit of this *Plan*

- When this *plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *plan*s during a *claim determination period* are not more than 100 percent of total *allowable expense*s. The difference between the benefit payments that this *plan* would have paid had it been the primary *plan* and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this *plan* to pay any *allowable expense*s, not otherwise paid during the *claim determination period*. As each claim is submitted, this *plan* will:
  1. Determine its obligation to pay or provide benefits under its *contract*;
  2. Determine whether a benefit reserve has been recorded for the covered person; and
  3. Determine whether there are any unpaid *allowable expense*s during that claims determination period.

  If there is a benefit reserve, the secondary *plan* will use the covered person's benefit reserve to pay up to 100% of total *allowable expense*s incurred during the *claim determination period*. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new *claim determination period*.

- If a covered person is enrolled in two or more *closed panel plan*s and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*; *COB* shall not apply between that *plan* and other *closed panel plan*s.

Right to Receive and Release Needed Information

Certain facts about health care *coverage* and services are needed to apply these *COB* rules and to determine benefits payable under this *plan* and other *plan*s. *ADVANTAGE* may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plan*s covering the person claiming benefits. *ADVANTAGE* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give *ADVANTAGE* any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *ADVANTAGE* may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under

this *plan*. *ADVANTAGE* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by *ADVANTAGE* is more than it should have paid under this *COB* provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 9: SUBROGATION/RIGHT OF REIMBURSEMENT

Subrogation means: If *your injury* or *illness* is caused by the acts or omissions of another party (including insurance *carriers* who are so liable), and *ADVANTAGE* has provided benefits under this *Certificate*, *ADVANTAGE* will have the right to be reimbursed if *you* receive any payment from the other party.

- *ADVANTAGE* is subrogated to all of *your* rights against any party legally liable to pay for *your injury* or *illness*.
- *ADVANTAGE* may assert this right independently of *you*.
- *You*, or anyone acting legally on *your* behalf must:
  - fully cooperate with *ADVANTAGE* in order to protect *ADVANTAGE*'s subrogation rights;
  - give notice of *ADVANTAGE*'s claim to third parties and their insurers who may be legally responsible;
  - provide *ADVANTAGE* with relevant information and sign and deliver such documents as *ADVANTAGE* reasonably request to secure *ADVANTAGE*'s subrogation claim; and
  - obtain *ADVANTAGE*'s consent before releasing any party from liability for medical expenses or services paid or provided.

If *you* enter into litigation or settlement negotiations regarding the obligations of other parties, *you* must not prejudice, in any way, *ADVANTAGE*'s subrogation rights.

SECTION 10: TERMINATION OF *COVERAGE*

The *coverage* provided in this *Certificate* for *you* and *your eligible dependents* and *young adults*, if any, may be terminated by *ADVANTAGE* upon the occurrence of any of the following events:

- You revoke your consent for ADVANTAGE to utilize your personal medical information for future, known, or routine needs for the purpose of treatment, payment, and health care operations.
- The termination of the *Contract* between *your Group* and *ADVANTAGE*.
- The *Group* fails to pay *ADVANTAGE premium* due on *your* behalf.
- *You* no longer qualify for eligibility based on the requirement of working or residing within the defined *ADVANTAGE service area.*
- Upon thirty-one (31) days prior written notice by *ADVANTAGE* if:
  - *You* fail to pay *copayments* or *coinsurance* required for *covered services*, or *premium* contributions, if any; or
  - *You* are unable to establish and maintain a satisfactory *hospital* or patient-*health professional* relationship with *participating hospitals* and *health professionals*; or
  - *You* commit fraud against *ADVANTAGE* or a *participating provider* by, for example:
    Allowing a non-*member* to use *your ADVANTAGE ID card* to obtain services;
    - Making any false statement or representation on *your* membership application;
    - Falsifying a prescription, stealing or otherwise misappropriating a prescription blank(s) or other property of a *participating provider* of *ADVANTAGE*;
    - Altering *your* medical record; or
    - Obtaining similar drug therapy or prescriptions from two or more *providers*, without *proper referral* or without informing the *providers* of *your* complete prescription profile, when done for the purpose of providing such prescriptions to someone other than the person for whom the medication was intended or for the purpose of self-administration of multiple prescriptions without the knowledge or approval of *your PCP*.
- *You* behave in a violent or abusive manner toward the staff of an *ADVANTAGE participating physician*, a *provider network*, or *ADVANTAGE*;
- *You* otherwise repeatedly violate the terms of this *Certificate* or *ADVANTAGE* rules; or
- *You* fail to cooperate with *ADVANTAGE* in the administration of the *coordination of benefits* provisions set forth in this *Certificate*.
- For other good cause as may from time to time be permitted by law. If membership is terminated for any of the grounds specified in this section, all rights to service cease as of the date of termination and there is no right to convert to an individual *carrier*.
- *Your spouse* will cease to be eligible for *coverage* hereunder on the first of the month following the month in which a final decree of dissolution of the marriage is recorded, unless *coverage* is continued in accordance with the terms of this *Certificate* or unless terminated sooner pursuant to the terms of this *Certificate.*

- If *you* are eligible to be covered under Medicare, *you* must enroll in Part A and Part B Medicare *coverage* on the date eligible in order to continue *coverage* under this *Certificate*. An exception to this rule applies to an actively employed *member* or the *spouse* of an actively employed *member* when *ADVANTAGE* is the primary payor. "Deemed Entitlement to Medicare" means any Covered Person who is an eligible retiree or the *spouse* of an eligible retiree shall be deemed to have enrolled for all Medicare Part A and Part B *Coverage* for which such Covered Person is eligible at the time such Covered Person first becomes eligible as if such Covered Person were enrolled in all such Medicate *Coverage*. In cases where Medicare is primary, the Plan estimates Medicare's primary share and pays only the secondary charges.
- *Your* child's *coverage* will terminate once he/she has reached the attainment of the limiting age, unless *coverage* is extended as described in the "Eligibility, Enrollment, *Coverage*" Section of this *Certificate* or is terminated sooner due to the terms of this *Certificate* . If you wish to obtain coverage under the Young Adult Coverage Rider you must notify your employer within 31 days of the dependent reaching the limiting age otherwise coverage will terminate.
- Termination of *coverage* for *you* and any enrolled family members, including a *young adult* due to termination of employment shall be determined by the *Group*; not withstanding any continuation of *coverage* addressed elsewhere in this *Certificate* .

If *you* believe that *coverage* has been canceled or not renewed because of *your* health status, need for health care services or exercise of *your* rights under the *grievance* procedure, *you* may request review by *ADVANTAGE* or by the Department of Insurance. Please refer to the "*Grievance*s and Appeals" Section of this *Certificate.*

In the event of the termination of the *Contract* between *Group* and *ADVANTAGE* or enrollment termination of any individual *member*, *coverage* for any prescription medication provided for under this *Certificate* will only be provided for the specific quantity of prescription medication that will actually be used or consumed by the *member* through the last day of eligibility, regardless of the pharmacy source for the medication. *Member* will be financially responsible for all quantities of prescription medication that will be used or consumed after the last day of eligibility, even if that medication is dispensed as part of a prescription partially covered by this *Certificate* prior to the termination.

Voluntary termination

- If *you* choose *coverage* under any other Plan that is offered by, through, or in connection with *your Group*, in lieu of *coverage* with *ADVANTAGE*, *coverage* for *you* and *your eligible dependents* will terminate on the date and time that the other *coverage* becomes effective. *Your Group* agrees to notify *ADVANTAGE* immediately when *you* elect other *coverage*.
- *You* may terminate *your coverage* and *your eligible dependent'(s')* or *young adult'(s') coverage*, if there is a qualified change in family status or during open enrollment, by giving written notice to *your Group*. The termination shall be effective on the last day of the month upon receipt of such notice by *ADVANTAGE* unless otherwise specified.

Your coverage (and *dependents* or *young adults* if applicable) shall terminate on the date determined by *your Group*.

Certificates of *Creditable Coverage*

If *your coverage* with *ADVANTAGE* terminates, *you* may be asked by the replacement *carrier* for a Certificate of *Creditable Coverage*. "*Creditable Coverage*," with respect to an individual, is *coverage* of the individual under any of the following types of insurance plans:

- a *Group* health plan or individual health plan;
- Part A or B of Medicare;
- Medicaid;
- CHAMPUS;
- a medical care program of the Indian Health Service or tribal organizations;
- a state health benefits risk pool, such as Children's Health Insurance Program;
- the federal employees health benefits program;
- a public health plan; (a plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance *coverage* to individuals);
- a health benefit plan under the Peace Corps Act; or
- a church plan.

In the event that *you* disenroll from *ADVANTAGE*, the Certificate of *Creditable Coverage* will help *your* new insurance *carrier* determine to what extent its *preexisting medical condition* exclusions apply, if any. If *you* were not without *coverage* for more than 63 days, the new insurance company must reduce its *preexisting medical condition* exclusions under *your* new insurance policy. *ADVANTAGE* will provide *you* with a Certificate of *Creditable Coverage* upon *your* disenrollment that will show the *effective date* of *your coverage* with *ADVANTAGE*. *ADVANTAGE* will make these Certificates available when:

- *You* are no longer eligible with *ADVANTAGE*;
- *You* reach the end of Consolidated Omnibus Budget Reconciliation (COBRA) *coverage*; and/or
- Upon *your* request, but only if the request is made within 24 months after *coverage* ends. *ADVANTAGE* will also provide to *your* new insurance *carrier*, upon request, a *Certificate* explaining *your* benefits under *ADVANTAGE*

SECTION 11: CONTINUATION OF *COVERAGE*

Do I have the option of continuing my *coverage* after termination?

- **Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986**

  If *you* are covered under a *Group* which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, the following shall apply:

  In order to obtain COBRA to continue *coverage* under this *Certificate*, *your Group* must:
  - notify *you* of *your* right to continued *Group coverage*, as required by federal law;
  - notify *ADVANTAGE* as soon as possible when *you* elect COBRA, including the date *your* COBRA *coverage* becomes effective;
  - collect and forward all applicable *premiums* to *ADVANTAGE* on a timely basis.

  If *you* have any questions about COBRA, *you* should speak with *your Group* directly.

- **Continuation of *Coverage* under Disability**

  You may become totally disabled while covered under this *Certificate* and still be totally disabled at the time this *Certificate* terminates or non-renews. If so, and if *you* pay the *premiums* that apply, *you* will be allowed to extend *your* benefits, under this *Certificate*, for the condition causing such disability, until the sooner of:
  - The date *you* become covered under, or eligible to be covered under, another *carrier* or policy affording similar benefits;
  - A period of three (3) months from the date *coverage* hereunder would have otherwise ended had *you* not been so disabled; or
  - The date *you* cease to be totally disabled.

  Benefits will not be said to be "similar" if *you* would be subject to a *pre-existing medical condition* or waiting period covering the disabling condition under the replacement policy. For the purposes of this *Certificate* , "total disability" means a disease or bodily *injury* (excluding normal pregnancy) which, in fact prevents or may reasonably be expected to prevent *you* from engaging, for a period of at least one (1) year, in any work for which *you* are or become qualified by reason of education, training or experience; or which prevents or may be expected to prevent *you* from performing, for a period of at least one (1) year, the important activities normal for a person of that age and family status. The fact that *you* are in the *hospital* at the time the *Certificate* ends is not by itself proof of "total disability". Nothing in this Section shall be deemed to prevent *ADVANTAGE* from coordinating benefits with the prior *carrier* or with another *Group carrier* with whom a totally disabled *member* may have health care *coverage*.

- **Individual Conversion**

  You may be eligible to obtain Individual Conversion *coverage* after *your* benefits with *your Group*, *ADVANTAGE* and/or COBRA expire. The *Individual Conversion Contract* is provided through *ADVANTAGE* Health Solutions, Inc. To obtain more information, contact ADVANTAGE Health Solutions at 9045 River Road, Ste 200 Indianapolis IN 46240, 1-800-553-8933.

  You may be entitled to an *Individual Conversion Contract*, without evidence of insurability, if:

  - *You* meet the eligibility requirements for an *Individual Conversion Contract* pursuant to Indiana Code 27-8-15-31;
  - *You* were continuously covered under this *Certificate* for at least 90-days;
  - *You* request the conversion policy from *ADVANTAGE* within 30 days of loss of *coverage*; and
  - *You* cease to be covered under this *Certificate* as a result of:
    - leaving *your Group* or a reduction in *your* hours of employment;
    - the *subscriber's* death or termination of marriage; or
    - ceasing to meet the definition of *eligible dependent.*

  If eligible for COBRA *coverage*, *you* must exhaust COBRA *coverage* before requesting a conversion policy. The conversion policy will be issued without regard to health status or requirements for health care services. If *you* elect to exercise this conversion privilege, the conversion shall be effective retroactive to the date and time *coverage* terminated under this *Certificate*, subject to the payment of any applicable *premium* due.

  You must pay *ADVANTAGE*, less any *copayment* and *coinsurance*, for the reasonable value of health services or benefits provided under this *Certificate* during the 30-day election period, if the conversion privilege is not exercised.

- **Extension of *Coverage* If *You* Are Confined to the *Hospital***

  If *you* are *hospital*ized for a medical or surgical condition on the date of termination of this *Certificate*, *you* will have continuation of *coverage* for *inpatient* services until the sooner of:
  - *Your* discharge from the *hospital*;
  - Sixty (60) days pass after the termination date of this *Certificate* ;
  - *You* obtain *coverage* from another *carrier* which includes *coverage* for *inpatient* services provided by this *Certificate* ;
  - Termination of *your Group's Group Service Agreement* by *ADVANTAGE*, as determined by:

- The *effective date* specified in written communication sent to *ADVANTAGE* by *your Group*, or
- Failure to pay a *premium* within the grace period permitted under the *Group Service Agreement*.

- Termination of *your coverage* and this *Certificate* by *ADVANTAGE* due to:
  - *You* knowingly providing false information to *ADVANTAGE*;
  - *Your* failure to comply with the rules stated in this *Certificate* ; or
  - *You* fail to pay *premium* within the grace period permitted in *your Group's Group Service Agreement*.

- **Exceptions to Continuation of *Coverage* and Conversion**

  Neither *you* nor *your eligible dependents* will be eligible for continuation of *coverage* under COBRA or for conversion to an *Individual Conversion Contract* if any of the following circumstances apply:

  - *You* do not meet the eligibility guidelines for an *Individual Conversion Contract* set forth in Indiana Code 27-8-15-31;
  - *Coverage* was terminated by *ADVANTAGE* or *your Group*; or
  - *You* have moved out of the geographic area in which *ADVANTAGE* is licensed to operate (Applies to individual conversion only).

In the event that *you* are deemed ineligible for conversion, *your eligible dependents* will also be deemed ineligible for conversion, unless otherwise required by law.

SECTION 12: OTHER IMPORTANT INFORMATION

Care Management

ADVANTAGE is committed to providing *members* with highest quality of care in the most cost-effective manner. In order to meet this endeavor, *ADVANTAGE* manages care using the following:

- Proper Referral Process **–**If services are not available within the *participating provider network*, *ADVANTAGE* will work with the *member* and *referring physician* to refer the *member* to the appropriate *provider* of service based on their condition.

- *Pre-Certification* **–** Pre-approval or certification of certain services (i.e. Physical Therapy, *Hospital*izations, etc.). *Your referring physician* is responsible for obtaining any *pre-certifications* unless *you* are a Point of Service *member*, where this is *your* responsibility.

- Concurrent Review **–** A review conducted of all *inpatient* admissions to assess whether there is a need for a continued stay. This process ensures that *members* only stay as long as *medically necessary* and at the same time are not discharged prior to necessity.

- Discharge Planning **–** This process is in place to ensure appropriate and timely discharge from the *hospital* to a more appropriate level and setting of care such as home health care.

- Case Management **–** This program is designed to be used in cases of *members* who are in need of long term care. A nurse is assigned to the *member* to work with the *member's physicians* and the *member* about a treatment plan. The patient, *provider* and Case Manager must all agree on the most cost effective treatment method, while assuring quality medical care.

- Preventive Health **–** Each of *ADVANTAGE's* benefit plans offer preventative health benefits designed to promote wellness and early detection of potential health problems.

- Disease Management **–***ADVANTAGE* empowers *members* who have conditions like Asthma, Hypertension, Cardiac Heart Failure, Depression, and Diabetes by providing them information on their condition to assist them with their conditions. *ADVANTAGE* provides them with newsletters and other materials on their conditions. Also, a member can choose to enroll and actively participate in *ADVANTAGE*'s Disease Management to receive discounted copays for certain disease-specific medications.

Provider Termination

- Occasionally, a *physician* may no longer participate with *ADVANTAGE* due to retirement, death, relocation, termination, etc. If *your PCP* or *SCP* ceases to be an *ADVANTAGE participating provider*, *ADVANTAGE*'s Member Services Department will make good faith efforts to notify *you* within 30 days prior to the *effective date* of termination. *You* will receive instructions on how to select a new *physician*.

- If *you* are currently in active treatment with the terminating *physician*, or *you* are in *your* third trimester of pregnancy, please contact an *ADVANTAGE* Member Services Representative. *You* may be able to continue *your* care with the *physician* until the completion of *your* treatment or up to 90-days, whichever is shorter. A representative will assist *you* or direct *you* to *ADVANTAGE*'s Care Coordinator. *ADVANTAGE*'s goal is to ensure *you* have access to continuity of care until *your* current treatment plan has ended, or until *your* pregnancy has been delivered.

- If *you* need an updated *Provider Directory* or other assistance in selecting a *physician*, *ADVANTAGE*'s Member Services Department will help *you*.

- Upon termination of a contract with a *participating provider*, *ADVANTAGE* shall be liable for payment of *covered services* rendered by the *provider* to *you* under the care of the *provider* at the time of termination until services being rendered to *you* by the *provider* are completed, unless *ADVANTAGE* makes reasonable and medically appropriate provision for assumption for services by another *provider*.

Notice of Material *Provider* Change
ADVANTAGE will provide written notice to *you*, within a reasonable time, after learning of an action by a *participating provider* that has a material effect on the *Group* or *you*. Examples of such actions may include: leaving *ADVANTAGE*'s *participating provider network*; material breach of contract; or being unable to perform key contract terms, but only if any of those actions affects *you* in a material way.

Utilization Management (UM) Decision Maker
- UM decision making is based only on appropriateness of care and service and existence of *coverage*.
- *ADVANTAGE* does not specifically reward *provider*s or other individuals for issuing denials of *coverage* or service care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Medical Technology Assessment
- *ADVANTAGE* provides a process to evaluate new medical technologies, services and pharmacological treatment to assure appropriate access to such services by the *member* population. *ADVANTAGE* develops protocols for new technology proactively and reactively. As *ADVANTAGE* becomes aware of new technology, the new technology guidelines outlined in this process are followed to prepare *ADVANTAGE*'s position regarding the new technology in anticipation of a future request.
- The *member's physician* must request an approval, prior to the service date and in writing, regarding the recommended treatment or service that is a new medical technology, *experimental* or investigative treatments and services.
- *ADVANTAGE* has available participating specialists, sub-specialists, pharmacists, and a referral center (Hayes, Inc.) to assist with the review and determination regarding new medical technology.
- *ADVANTAGE* contracts with Hayes, Inc. to provide a database and access to research regarding various medical technologies, including new use of existing technologies and newly developed technologies. Elements of the Hayes technology assessment process include:
  - Application of rigorous methods of scientific inquiry which encompass a thorough search of the peer-reviewed scientific literature
  - Critical appraisal of the data reported with respect to study design and clinical significance of outcomes
  - Comparative analysis of alternatives

  There are many healthcare technologies assessed by Hayes, Inc. and accessible to *ADVANTAGE* including:
  - Medical and surgical procedures, including transplants
  - Drugs and pharmaceuticals
  - Diagnostic and screening tests
  - Alternative therapies
  - Behavioral Health procedures
  - Medical devices/equipment
- Requests for approval of new medical technology procedures/services that involve a *member* whose health situation is life threatening will be resolved and the *physician*/*member* notified within 72 hours of the request.
- Technology assessments for non-urgent situations should be submitted 5-7 days prior to the service date if possible to allow adequate time to investigate the proposed treatment or service. A response to a written request for non-urgent technology assessment is provided within 15 *calendar* days of receiving the request. Medical Management notifies the *PCP*, *SCP*, and facility by telephone of the recommendation to approve or deny *coverage* within one business day. Notification letters are mailed to the *PCP*, *SCP*, and *member* within two (2) business days of the determination to approve or deny new medical technology.
- If the Medical Director denies a request for a new technology service/procedure, a denial notification letter is sent to the *member*, *PCP*, and *SCP* outlining the principle reason for the denial, criteria utilized, and the appeals process.

Severability
In the event that any provision of this *Certificate* is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this *Certificate*, which shall continue in full force and effect in accordance with its remaining terms.

Worker's Compensation
This *Certificate* is not in lieu of and does not affect any requirement or *coverage* by Worker's Compensation Insurance.

Rights to *Covered services* Not Transferable
No person other than *you* or *your eligible dependent* is entitled to receive health care services or other benefits to be furnished by *ADVANTAGE* under this *Certificate*. The right to health care services or other benefits is not transferable.

Right to Change Control when required by Law
ADVANTAGE will apply this *Certificate* in agreement with state and federal laws and regulations. If any part of this *Certificate* does not agree with state or federal laws or regulations, this *Certificate* is deemed amended and *ADVANTAGE* will change *ADVANTAGE*'s procedures to conform to the laws and regulations. *ADVANTAGE* reserves the right to terminate the C*ontract* and re-rate the C*ontract* based on the changes at the time of renewal of this *Certificate*.

Assignment of Benefits Payments
You are not permitted to assign benefits or payments for services covered under this *Certificate*.

Relationship Among Parties Affected by this *Certificate*

- The relationship between *ADVANTAGE* and participating *health professional*s and/or *provider networks* is that of independent contractors. *ADVANTAGE* is not a "professional" corporation and so does not practice medicine or direct the professional practice of medicine by any *health professional*. Neither participating *health professional*s nor *provider networks* are employees of *ADVANTAGE*, nor are they agents of *ADVANTAGE*. Nor is *ADVANTAGE* or any of *ADVANTAGE*'s employees an employee or agent of the *health professional*s or *provider networks* who participate in *ADVANTAGE*'s provider panel. *Health professional*s are responsible for maintaining professional-patient relationships with the *member*. *Health professional*s are solely responsible to the *member* for all medical services.

- *Participating providers* may receive a financial incentive from *ADVANTAGE* to appropriately manage the provision and cost of services rendered to *you*.

- Neither the *Group*, nor any *member*, is an agent or representative of *ADVANTAGE*. Neither the *Group*, nor any *member*, shall be liable for any acts or omissions of *ADVANTAGE*, *ADVANTAGE*'s agents or employees, or of any *participating health professional*, or *participating hospital*, or any other person or organization with which *ADVANTAGE*, *ADVANTAGE*'s agents or employee, has contracted for the performance of services under this *Certificate*.

- Certain *members* may, for reasons personal to themselves, refuse to accept procedures or courses of treatment recommended by an *ADVANTAGE participating health professional*. *Health professionals* shall use their best efforts to render all necessary and appropriate professional services in a manner compatible with the *member's* wishes, insofar as this can be done consistently with the *participating health professional's* judgment as to the requirements of proper medical practice. If a *member* refuses to follow a recommendation treatment or procedure, and a *participating health professional* believes that no professionally acceptable alternative exists, such *member* shall be so advised. The *member* will have the right to consultation (*second opinion*) from an appropriate *ADVANTAGE participating physician* regarding his or her medical condition. If both *participating physicians* agree as to the course of treatment, and the *member* still refuses to follow the recommendation, *ADVANTAGE* will cease to *provide covered services* or pay for treatment for such condition. At such time the *member* agrees to follow the recommended treatment or procedure, *covered services* will resume.

SECTION 13: NOTICE OF PRIVACY PRACTICES

ADVANTAGE is required by applicable federal and state laws to maintain the privacy of *your* health information. We are also required to give *you* this notice about our privacy practices, our legal duties, and *your* rights concerning *your* health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2005, and will remain in effect until we replace it.

ADVANTAGE reserves the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. *ADVANTAGE* reserves the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information *ADVANTAGE* created or received before we made the changes. Before we make significant change in our privacy practices, *ADVANTAGE* will change this notice and send the new notice to our health *subscribers* at the time of the change.

You may request a copy of our notice at any time. If *you* would like to request a copy or obtain additional information, please contact us using the contact information listed at the end of this notice.

Uses and Disclosures of Health Information
The sections below describe the ways *ADVANTAGE* uses and releases *your* health information. *Your* health information is not shared with anyone who does not have a "need to know" to perform one of the tasks listed below.

- **Treatment**: *ADVANTAGE* may use *your* health information or disclose it to third parties to coordinate and oversee *your* medical care. For example, we may use *your* health information to help *you* find a doctor or a *hospital* that can treat *your* specific health needs.

- **Payment**: *ADVANTAGE* may use *your* health information or disclose it to third parties to pay for *your* medical care. For example, we may use *your* health information when we receive a claim for payment. *Your* claims tell us what services *you* received and may include a diagnosis. *ADVANTAGE* may also disclose this information to another insurer if *you* are covered under more than one health plan.

NOTE: Non-English speaking *member*s can access Member Services, Utilization Management and Care Coordination, and other *ADVANTAGE* services for *member* treatment, payment or *ADVANTAGE* operations. *ADVANTAGE* contracts with Language Line Services to assist non-English speaking *member*s in accessing *ADVANTAGE* resources and getting answers to questions. The interpreters may communicate directly with the *member* and *ADVANTAGE* representatives to resolve *member* questions. The communication may include information related to *your* health care. As concepts familiar to English speakers often require explanation or elaboration in other languages and cultures, the interpreters will then convey the communications meaning-for-meaning not necessarily word-for-word.

- **Health Care Operations**: *ADVANTAGE* may use *your* health information and disclose it to third parties in order to assist in *ADVANTAGE*'s everyday work activities such as looking at the quality of *your* care, carrying out utilization review, and *ADVANTAGE*'s business planning. For example, *your* health information may be released to members of *ADVANTAGE* staff to review the quality of care and outcomes. *Your* health information may be released to doctors or doctor groups involved in *your* care to improve patient care. Additionally, *ADVANTAGE* publishes the Health Group Data Information Set (HEDIS) which is a report of *ADVANTAGE member*'s health care measurement data. *ADVANTAGE* also publishes the Commercial Adult Health Plan Survey (CAHPS) results, which measures *ADVANTAGE member* satisfaction. *ADVANTAGE*'s policy reflects that we utilize methodologies that protect the identity of individual *member*s, such as not connecting specific survey responses to individual *member*s, not providing any *member* specific data in the measurement data, etc.

  NOTE: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to inform you of your right, our legal duties and our privacy practices. By enrolling in this Plan, *you* understand that *ADVANTAGE* has the right to utilize *your* personal medical information for future, known or routine needs for the purposes of treatment, payment, and health care operations. ***You* understand this consent is a condition of *your* enrollment in *ADVANTAGE* and *you* have the right to revoke this consent in writing at any time.**

- **To *You* and Upon *Your* Authorization**: *ADVANTAGE* must disclose *your* health information to *you*, as described in the Individual Rights section of this notice, below. *You* may give us written authorization to use *your* health information or to disclose it to anyone for any purpose. If *you* give us an authorization, *you* may revoke it in writing at any time. *Your* revocation will not affect any use or disclosure permitted by *your* authorization while it was in effect. Without *your* authorization, we may not use or disclose *your* health information for any reason except those described in this notice

- **To *Spouse* or Parent:** Unless *you* specifically request that *ADVANTAGE* not disclose such information, *ADVANTAGE* may disclose *your* health information to *your spouse* or parent, in compliance with applicable privacy laws, to help with *your* health care or payment for health care services. *Your* request to not disclose health information to a *spouse* or parent must be in writing, signed by the individual authorized to make such a request, and sent to the Contact Information listed at the end of this notice.

- **To Plan Sponsor (*Group*):** *ADVANTAGE* may disclose limited summary health information about *you* to *your* plan sponsor (*Group*). "Summary Health Information" is information that summarizes the claims history, claims expenses or types of claims experienced by *you* and other members of *your Group* health plan, from which specific identifiers have been deleted. However, *ADVANTAGE* may disclose *your* identifiable health information and the identifiable health information of others enrolled in *your Group* health plan to *your* plan sponsor (*Group*) only:
  1. If *you* authorize us to disclose the information by completing an authorization form; or
  2. If necessary for the *Group* to perform plan administration functions on behalf of the *Group* health plan, and *ADVANTAGE* receives a certification from the plan sponsor (*Group)* that satisfies all of the requirements of HIPAA, which allow for the release of identifiable health information.

- **To Family and Friends**: If *you* agree, or if *you* are unavailable to agree, when the situation, such as medical *emergency* or disaster relief, indicates that disclosure would be in *your* best interest, *ADVANTAGE* may disclose *your* health information to a family member, friend or other person to the extent necessary to help with *your* health care services.

- **Underwriting**: *ADVANTAGE* may receive *your* health information for underwriting, *premium* rating or other activities relating to the creation, renewal or replacement of a C*ontract* of health insurance or health benefits. We will not use or further disclose this health information for any other purpose, except as required by law, unless the *Contract* of health insurance or health benefits is placed with us. In that case, our use and disclosure of *your* health information will only be as described in this notice.

- **Marketing**: *ADVANTAGE* may use *your* health information to contact *you* with information about health-related benefits and services, including but not limited to, *ADVANTAGE*'s disease management programs and *quality improvement* activities that may be of interest to *you*. We may disclose *your* health information to a business associate to assist us in these activities. Unless the information is provided to *you* by a general newsletter, in person, or is for products or services of nominal value, *you* may opt-out of receiving further such information by telling us using the contact information listed at the end of this notice.

- **Research; Death; Organ Donation**: *ADVANTAGE* may use or disclose *your* health information for research purposes in limited circumstances. We may disclose the health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.
- **Public Health and Safety**: *ADVANTAGE* may disclose *your* health information to the extent necessary to avert a serious and imminent threat to *your* health or safety or the health or safety of others. We may disclose *your* health information to a government agency authorized to oversee the health care system or government programs or its contractors, and public health authorities for public health purposes. We may disclose *your* health information to appropriate authorities if we reasonably believe that *you* are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law**: *ADVANTAGE* may use or disclose *your* health information when we are required to do so by law. For example, we must disclose *your* health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy law. We may disclose *your* health information when authorized by workers' compensation or similar laws.
- **Process and Proceedings**: *ADVANTAGE* may disclose *your* health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose *your* health information to law enforcement officials.
- **Law Enforcement**: *ADVANTAGE* may disclose limited information to a law enforcement official concerning the health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the health information of any inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- **Military and National Security**: *ADVANTAGE* may disclose to Military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Other Uses of Health Information – By Authorization Only
Other uses and disclosures of health information not covered by this Notice or the law that apply to us will be made only with *your* written authorization. If *you* provide us with an authorization to use or release health information about *you*, *you* may end that authorization, in writing, at any time. If *you* end *your* authorization, we will no longer use or release health information about *you* for the reasons covered by our written authorization. *You* understand that we are unable to take back any disclosures we have already made with *your* authorization.

A parent, legal guardian, or properly named patient advocate may represent *you* if *you* cannot provide an authorization. Authorization is needed for certain release of information dealing with mental health issues, substance abuse issues, HIV/AIDS and *grievance*s. We can provide *you* with a sample authorization form. *You* may also end an authorization by writing to *ADVANTAGE* at the contact information list at the end of this Notice.

Confidentiality in All Settings
ADVANTAGE has policies and procedures in place that protect the privacy of *your* information.
- Every employee signs a statement when they are hired that they understand they are required to keep *member* information private. They also learn about the actions the company will take if the privacy policies are not followed.
- *ADVANTAGE* has strict control of access to electronic, and paper information specific to *member*s. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for *member*s.

ADVANTAGE tells all third parties with whom we share information about our privacy policies. These third parties must follow our privacy policies unless they have policies of their own equal to ours. In addition, *ADVANTAGE* will not share any *member* information with a *Group* without specific authorization from the *member*.

ADVANTAGE's Compliance Committee reviews our confidentiality policies and procedures every year. These committees also reviews how we collect, use, dispose of, and disclose *your* information. *Members* (or prospective *members)* and *providers* have the right to review *ADVANTAGE*'s privacy policies and procedures. *You* may get copies by contacting Member Services.

Changes to this Notice
ADVANTAGE has the right to change the terms of this Notice. We have the right to make these changes, which apply to health information we already have about *you* as well as any we receive in the future. We will always post a copy of the current Notice on *ADVANTAGE*'s web site. *You* will also receive materially revised Notices within 60 days of their effective date.

Individual Rights
- **Access**: *You* have the right to inspect or obtain copies of *your* health information, with limited exceptions. *You* may request that *ADVANTAGE* provide copies in a format other than photocopies (i.e. electronic). We will use the format *you* request unless we cannot practicably do so.

- **Disclosure Accounting**: *You* have the right to receive a list of instances in which *ADVANTAGE* or our business associates disclosed *your* health information obtained or created since April 14, 2003 for purposes other than treatment, payment or health care operations and certain other authorizations. We will provide *you* with the date(s) on which we made the disclosure, the name(s) of the person or entity (ies) to whom we disclosed *your* health information, a description of the health information disclosed, and certain other information. If *you* request this list more than once in 12-month period, we may charge *you* a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

- **Restriction Request:** *You* have the right to request that *ADVANTAGE* place additional restrictions on our use or disclosure of *your* health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our *Agreement* (except in an *emergency*). Any *Agreement ADVANTAGE* may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an *Agreement* on *your* behalf. *ADVANTAGE* will not be bound unless our *Agreement* is so memorialized in writing.

- **Confidential Communication**: *You* have the right to request that *ADVANTAGE* communicate with *you* in confidence about *your* health information by alternative means or to an alternative location. *You* must inform us that confidential communication by alternative means or to an alternative location is required to avoid endangering *you*. *You* must make *your* request in writing, and *you* must state that the information could endanger *you* if it is not communicated in confidence by the alternative means or to the alternative location *you* want. *ADVANTAGE* must accommodate *your* request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect *premiums* and pay claims under *your* health plan.

- **Amendment**: *You* have the right to request that *ADVANTAGE* amend *your* health information. *Your* request must be in writing, and it must explain why the information should be amended. *ADVANTAGE* may deny *your* request if we did not create the information *you* want amended or for certain other reasons. If we deny *your* request, we will provide *you* a written explanation. *You* may respond with a statement of disagreement to be appended to the information *you* wanted amended. If we accept *your* request to amend the information, we will make reasonable efforts to inform others, including people *you* name, of the amendment and to include the changes in any future disclosures of that information.

- **Electronic Notice**: If *you* receive this notice on our web site (www.advantageplan.com) or by electronic e-mail, *you* are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If *you* are concerned that we may have:

- Violated *your* privacy rights;
- *You* disagree with a decision we made about access to *your* health information;
- In response to a request *you* made to amend or restrict the use or disclosure of *your* health information; and/or
- In response to a request *you* made to have us communicate with *you* in confidence by an alternative means or at an alternative location

You may complain to *ADVANTAGE* using the contact information listed at the end of this notice. *You* also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide *you* with the address to file *your* complaint with the U.S. Department of Health and Human Services upon request.

ADVANTAGE supports *your* right to protect the privacy of *your* health information. We will not retaliate in any way if *you* choose to file a complaint with us or the U.S. Department of Health and Human Services. If *you* want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

ADVANTAGE Health Solutions, Inc.SM
Member Services Department
9045 River Road, Ste 200
Indianapolis, IN 46240
1-800-553-8933
1-800-743-3333 (TDD for hearing impaired)
Website: www.advantageplan.com

SECTION 14: ANTI-FRAUD POLICY STATEMENT

ADVANTAGE is committed to the fight against fraud and corruption. *ADVANTAGE* employees, management and Directors refrain from conduct that may violate the fraud and abuse laws. These laws prohibit:

- direct, indirect or disguised payments in exchange for the referral of patients;
- the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and

- making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

Employees, *members, providers* and contractors can provide valuable information to alert *ADVANTAGE* to possible fraud and abuse issues. Therefore, *ADVANTAGE* has established reporting mechanisms to ensure timely identification and resolution of issues or suspicions of fraud. We have contracted with FPV, Inc. to establish and manage an external hotline. The hotline will allow employees, *members, providers*, and contractors to report suspicion of fraud anonymously or in confidence and without fear of retaliation. Individuals who report problems and concerns in good faith via the hotline will be protected from any form of retaliation. All those who are employed in the external hotline operation are expected to act with utmost discretion and integrity in assuring that information received is acted upon in a reasonable and proper manner. Each FPV employee involved with the *ADVANTAGE* hotline will be required to sign a Confidentiality Agreement.

You may call the *ADVANTAGE* Hotline at **1-888-333-9576**. Our current call center hours are Monday – Friday from 8am – 9pm, and Saturday from 8am – 6pm. During off-hours *ADVANTAGE* has an automated voicemail system and returns all calls on that line.

SECTION 15: GLOSSARY OF TERMS

This section defines terms that have special meanings. The word or phrase is defined in this section or elsewhere in this *Certificate*.

ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE) - Corporation *authorized* to do business in Indiana, licensed under the Indiana Health Maintenance Organization law, which has a C*ontract* with *your* employer *group* (*Group*) to arrange for health care services for m*embers* as described in this *Certificate*.

AGREEMENT or GROUP SERVICE AGREEMENT or CONTRACT or GROUP CONTRACT - The *Contract*, including any *amendments* or riders agreed to by *ADVANTAGE* and *your Group* that expresses the rights and obligations of both parties. It also describes the costs, procedures, benefits, conditions, limitations, *non-covered services*, and other obligations to which *members* are subject to under *ADVANTAGE*'s health maintenance organization.

AMBULANCE – A specially designed and equipped vehicle or aircraft that is used for the purpose of responding to *emergency* life-threatening situations and providing *emergency* transportation services. An *ambulance* must be certified as such in the state(s) in which it operates.

ANNUAL BENEFIT MAXIMUM - A maximum number of visits, days, sessions, or specific dollar amount that will be provided per *covered service*, per *member*, and per *calendar year*.

AT HOME POST DELIVERY CARE - Health care services provided to a woman at her residence, including, but not limited to: parent education, assistance and training in breast or bottle feeding; and any maternal and neonatal tests routinely performed during the usual course of *inpatient* care for the woman or her newborn child, including collection of an adequate sample for the hereditary and metabolic newborn screening. Services may be provided by: a *physician*; a *RN*; or an advanced practice nurse whose scope of practice includes providing postpartum care in the area of maternal and child health care. The *At home post delivery care* visit must be provided within 48 hours after the mother and newborn child are discharged from the *hospital*. At the mother's discretion, the visit may occur in the *participating provider*'s office.

AUTHORIZATION, AUTHORIZED SERVICES, PRIOR AUTHORIZATION, OR PRE-CERTIFICATION – A *covered service* which has been *authorized* in advance by *ADVANTAGE*.

BEHAVIORAL HEALTH NETWORK - A *participating behavioral health network* of mental health and substance abuse *providers* affiliated with a *member's* assigned *PCP*. The *participating provider network* is responsible for arranging behavioral health services, coordination of care, and case management.

BENEFIT PERIOD – A *benefit period* begins on the first day *you* go to a Medicare-covered *skilled nursing facility*. The *benefit period* ends when *you* have not been an *inpatient* at any *skilled nursing facility* for 60 days in a row. If *you* go to a *skilled nursing facility* after one *benefit period* has ended, a new *benefit period* begins. There is no limit to the number of *benefit period*s *you* can have. The type of care *you* actually receive during the stay determines whether *you* are considered to be an *inpatient* for *skilled nursing facility* stays.

BIOLOGICAL or BIOPHARMACEUTICAL DRUG means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. *Biological* or *biopharmaceutical products* typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct *physician* involvement, and significant *member* education. These services must be *authorized* by *ADVANTAGE*.

BRAND-NAME (DRUG) means a drug that has been manufactured under a patent and in accordance with the approval for the Food and Drug Administration (FDA).

CARRIER – An underwriter or insurer.

CALENDAR YEAR means the twelve-month period beginning on January 1 and ending on December 31.

CERTIFICATE OF COVERAGE (CERTIFICATE) - The document given to *you*, that describes both *your* and *ADVANTAGE*'s rights and duties. It includes the schedule of benefits and any *options*, amendments, riders or attachments to this document.

COINSURANCE and COPAYMENT – The amount a *member* must pay directly to a *participating provider* of *covered services* for those services and supplies. A *member* generally must pay this amount at the time *covered services* are received.

CONTRACT YEAR means the duration of *covered benefits* described in the A*greement* between *ADVANTAGE* and the *Group* and described on the cover page of this *Certificate*.

COORDINATION OF BENEFITS (COB) - An attempt by one of *ADVANTAGE*'s *participating provider's* and/or *ADVANTAGE* to recover the cost of care provided to a *member* from a third party. The third party may be another insurer, such as automobile, home, business, and/or renter, service plan, government third party payor, or other organization, which also provides *coverage* for a *member*'s health care needs. *Coordination of benefits* is subject to any limitations imposed by this *Certificate* or another applicable policy preventing such recovery.

COSMETIC – A service that involves physical appearance, but is not *medically necessary* and does not correct or materially improve a physiological function.

COVERED SERVICES or COVERAGE – Those services or supplies that a *member* is entitled to under this *Certificate*, if the services are *medically necessary* and *the member* has met all other requirements of this *Certificate.* The *Agreement* between *ADVANTAGE* and the *Group*, this *Certificate*, limit what *ADVANTAGE* will pay for some services and supplies. When *ADVANTAGE* says it will "Cover" a service or supply that means *ADVANTAGE* will treat the service as a *covered service*.

CUSTODIAL CARE - Care furnished for the purpose of meeting personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. *Custodial care* is not covered under this *Certificate*.

DEDUCTIBLE - The specific dollar amount of charges for *covered services* that *you* must incur before certain *covered services* will be paid.

DURABLE MEDICAL EQUIPMENT (DME) - Rental or purchase of *DME* is covered only when *medically necessary* and *authorized* by ADVANTAGE. *DME* can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of *illness or injury* and is suitable for use in *member's* home. Examples of *DME* include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, *hospital* beds, monitoring devices, oxygen-breathing apparatus and insulin pumps.

EFFECTIVE DATE OF COVERAGE – The date when *your coverage* begins under this *Certificate*.

ELIGIBLE DEPENDENT or DEPENDENT - means a person of the *subscriber's* family: who meets the eligibility requirements of the *Group* and eligibility requirements listed in this *Certificate*; for whom the *subscriber* has applied for membership; and for whom *premiums* have been paid by *Group* and/or *subscriber*. To be an *eligible dependent,* a person must meet *ADVANTAGE*'s *service area* requirement, (see *Service Area* definition) and be either: the legal *spouse* of the *subscriber*; a natural or adopted unmarried *dependent* child of the *subscriber*; other individual determined to be eligible for enrollment by the *Group*; or an unmarried *dependent* child for whom the *subscriber* is the legal guardian or foster parent or has been ordered by a Court or administrative order to provide health care *coverage.;*

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

EMERGENCY SERVICES - Services provided due to a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

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

EXPERIMENTAL or INVESTIGATIONAL - Any intervention (treatment, procedure, facility, equipment, drug device, service, or supply): that meets one or more of the following criteria:

- Intervention that is not generally and widely accepted in the practice of medicine in the U.S.; and whose effectiveness is not documented in peer-reviewed articles in medical journals published in the U.S. For interventions to be considered effective, journal articles should indicate that the intervention is more effective than other available, or, if not more effective, is safer or less costly.

- Interventions that are considered *experimental* or *investigational* by:
  - the U.S. Department of Health and Human Services;
  - the National Institute of Health; or

- any of their subsidiary agencies

• Drugs or medical devices *biological* products, or some combination thereof that the U.S. Food and Drug Administration (FDA) has not cleared or approved for commercial distribution, or that do not have other governmental agency approval as required by law.

• Use of an FDA cleared or approved drug, medical device, *biological* product or some combination thereof for a use: (1) that FDA has not cleared or approved and that would otherwise require such clearance or approval (i.e., an 'off-label' use); and (2) the effectiveness of which has not been documented in peer-reviewed articles in medical journals published in the U.S. For used of this type to be considered effective, such articles should indicate that using the drug, medical device, biological product, or some combination thereof for he particular use at issue is more effective than other products available for the proposed use, or, if not more effective, is safer or less costly.

FORMULARY - *ADVANTAGE* utilizes a prescription drug *formulary*. A *formulary* is a list of preferred *generic* and *brand name* prescription medications that have been approved by the Food and Drug Administration (FDA).

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

GRIEVANCE is a written or oral complaint submitted in accordance with the formal *grievance* procedure of *ADVANTAGE* by or on behalf of a *member* regarding any aspect of *ADVANTAGE* relative to the *member* that expresses dissatisfaction regarding the:

• Availability, delivery, appropriateness or quality of health care services
• Handling or payment of claims for health care services or;
• Matters pertaining to the contractual relationship between:
  i) a *member* and *ADVANTAGE*; or
  ii) a *Group* or individual C*ontract* holder and *ADVANTAGE*;
• Any concerns regarding confidentiality of information
and for which the *member* has a reasonable expectation that action will be taken to resolve or reconsider the matter that is subject of dissatisfaction.

GROUP means the *subscriber's* employer who has *contract*ed with *ADVANTAGE* to provide *member* and *eligible dependent*'s health benefits.

HEALTH PROFESSIONAL - A professional engaged in the delivery of health services who is licensed, where required, under the laws of the jurisdiction where services are delivered and operating within the scope of his/her license.

HOME HEALTH SERVICES - Health services delivered in a *member's* home setting and provided by an organization licensed by the State and operating with the scope of its license.

HOSPICE CARE OR FACILITY – a health care facility or a system of professional home visits and supervision, for supportive care of the *terminally ill.*

HOSPITAL - An acute care facility duly licensed in the jurisdiction where services are rendered.

ILLNESS - A sickness or disease and all related conditions and recurrences. The term *illness* includes pregnancy and all related conditions.

INJURY - An accident to the body that requires medical or surgical treatment.

INPATIENT - Confinement as a bed-patient for 24 hours or longer in a *hospital, SNF*, or *hospice facility.*

LATE ENROLLEE – As described in this *Certificate*, is a *subscriber* or *eligible dependent* who did not request enrollment with *ADVANTAGE*: during the initial enrollment period in which he/she was first entitled to enroll; or during any special enrollment period, and as described in this *Certificate*.

LICENSED PRACTICAL NURSE - Person who has been licensed by a State Board of Nurse Examiners or other state authority, and how is legally entitled to place the letters "LPN" after his name.

LOW PROTEIN MODIFIED FOOD PRODUCT means a food product that is (1) specially formulated to contain less than one (1) gram of protein per serving; and (2) intended to be used under the direction of a *physician* for dietary treatment of an *inherited metabolic disease*.

MAXIMUM ALLOWABLE AMOUNT – The amount that *ADVANTAGE* determines is the maximum payable for *Covered services you* receive, up to but not exceed charges actually billed. For a non-*participating provider* the *Maximum allowable amount* is the lesser of the actual charge or the standard rate under the contracted used with *participating providers.* The *Maximum allowable amount* is reduced by any penalties for which a *member* is responsible under the terms of this *Certificate.*

MEDICAL FOOD means a food that is (1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by a medical evaluation; and (2) formulated to be consumed or administered internally under the direction of a *physician*.

MEDICALLY or *CLINICALLY NECESSARY* is defined as:

1. appropriate for the symptoms, diagnosis, or treatment of the medical condition; and
2. provided for the diagnosis or direct care and treatment of the medical condition; and
3. within standards of good medical practice within the organized medical community; and
4. not primarily for the convenience of the member's *physician* or another provider; and
5. not otherwise subject to *non-covered services* under this *Certificate* ; and
6. the most appropriate procedure, supply, equipment, or service that can safely be provided. The most appropriate procedures, supplies, equipment, or service must satisfy the following requirements:

   i. there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the member with the particular medical condition being treated than other alternatives; and
   ii. generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
   iii. for *hospital* stays, acute care as an *inpatient* is necessary due to the kind of services the member is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an *outpatient* or in a less intensified medical setting

The fact that a provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies *medically necessary*.

MEMBER (you, your) - An eligible person enrolled in *ADVANTAGE*'s health plan, as a *subscriber* or *eligible dependent*.

NON-COVERED SERVICES are those services not covered under this *Certificate* and are listed as *non-covered services* in this *Certificate.*

OPEN ENROLLMENT PERIOD - Period of time established by *ADVANTAGE* and the *Group* during which eligible employees and their *eligible dependents* may enroll as new *members.*

OPTION - An addition or amendment to the *Agreement* indicating any additional *covered services* and the corresponding *member copayment*, *coinsurance*, and maximum benefit limits (if applicable).

OUT-OF-POCKET MAXIMUM - Maximum *coinsurance* amount for *covered services*, per *member* and per family per *calendar year*.

OUTPATIENT - Member who receives medical services, but is not an *inpatient*.

PARTIAL HOSPITALIZATION - A structured mental health and/or substance abuse treatment program with sessions of three hours or longer.

PARTICIPATING or CONTRACTING HOSPITAL – A *hospital* that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PHARMACY - A pharmacy or organization of pharmacies that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PHYSICIAN - A *physician* who contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PROVIDER - A *health professional* or other entity that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PCP or **PRIMARY CARE PHYSICIAN** – A *participating physician* selected by the *member* to be his/her primary health care *provider*. *Primary care physicians* may include Family or General *Physicians*, Internists, Pediatricians and OB-GYN's.

PHYSICIAN - An appropriately licensed *physician* or surgeon.

PHYSICIAN NETWORK, **PROVIDER NETWORK** means organized *group* of *physician*s, facilities and *health professionals* contracted with that has entered into *a* contract with *ADVANTAGE*. A *physician network* has as its primary purpose the delivery, or the arrangement for the delivery, of *covered services*.

POLICY MAXIMUM or CONTRACT MAXIMUM or AGREEMENT MAXIMUM – Total lifetime maximum dollar amount payable for *Covered services* the *member* receives under the *Agreement* issued to the *Group*, including any renewals, endorsements,

amendments or addendums thereto. If there is a lapse in *coverage*, the *policy maximum* applies to all benefits received both before or after the lapse.

PREMIUM – The total payment, including any contributions from *subscribers* or late charges, that the *Group* pays *ADVANTAGE* to maintain *coverage.*

PRE-EXISTING MEDICAL CONDITION – A physical or mental condition for which medical advice, diagnosis, care or treatment is recommended or received up to six (6) months prior to coverage *effective date*. Pregnancy is not considered a *pre-existing medical condition*. Genetic information may not be considered a *pre-existing medical condition* if there is no specific diagnosis of a current disease or medical problem related to the genetic test. A pre-existing medical condition may not apply to a newly born dependent child enrolled within 31 days of date of birth or a dependent child who is adopted by, or placed for adoption with, the subscriber and enrolled within the first 31 days of placement with the subscriber or within 31 days of the date of entry of the order granting the adopting parent custody of the child for purposes of adoption.

PRE-EXISTING MEDICAL CONDITION EXCLUSION PERIOD – The period of time during which services relating to *pre-existing medical conditions* are not considered *covered service*s under this *Certificate*. The *pre-existing exclusion period* is six (6) months from the effective date of coverage with *ADVANTAGE*, less the number of months exhausted under *prior creditable coverage.*

PRIOR CREDITABLE COVERAGE – C*reditable coverage you* had prior to *your effective date* with *ADVANTAGE* that was continuous. For the purpose of this section, "continuous" means *coverage* that was not interrupted by a break of 63 or more days in a row. There can be more than one break, but no single break can be 63 or more days in length. Proof of *prior creditable coverage* is determined by a Certificate of *Creditable Coverage*, which is a written Certificate of *your* prior *coverage* provided to *you* by *your* prior health *carrier*. The *Certificate* must identify *you* as the covered person, period of *coverage*, and waiting periods (if any).

PROPER REFERRALS - Process where a *member's physician* directs the *member* to seek or obtain *covered services* from another *participating or* <u>non</u>*-participating health professional* or *inpatient facility* subject to ADVANTAGE's *pre-certification* requirements.

PROVIDER - Any *hospital, physician,* pharmacy, *SNF*, individual, organization, or agency that is licensed to provide professional services within the scope of that license or certification.

PROVIDER DIRECTORY – A document listing *ADVANTAGE*'s *participating providers* available to *you* under this *Certificate* .

QUALITY IMPROVEMENT ("QI") COMMITTEE - Committee of *physicians and other health professionals* selected and approved by the *provider network* and/or *medical Group* to disseminate and maintain professional standards.

REGISTERED NURSE (RN) - A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "RN" after his name.

RENEWAL DATE - Date on which the *Agreement* will be renewed.

SECOND OPINION - Medical or surgical opinion that is provided by a *physician*, to reevaluate the condition. The *second opinion* is made with prior *authorization* from *ADVANTAGE*.

SERVICE AREA means the geographical area where the *member* must work or reside to be eligible to enroll, which **is 30 air** miles of the office of the *member's* assigned *PCP*.

SKILLED NURSING FACILITY or **SNF** - Institution, or a distinct part of an institution, which:

- is duly licensed in the state of Indiana; is regularly engaged in providing 24-hour skilled care under the regular supervision of a *physician* and the direct supervision of a *RN*;
- maintains a daily record on each patient; and
- provides each patient with active treatment of an *illness* or *injury*, or related rehabilitation, in accordance with existing standards of medical practice for that condition.

A *SNF* does not include any institution or portion of any institution that is primarily for rest, the aged, non-skilled care, or care of mental diseases or substance abuse.

SPECIALTY CARE PHYSICIAN (SCP) - A *physician* who has an identified specialty other than a family practice, internal medicine, or pediatrics; and who is not acting in the role of a *PCP* to the *member* at the time services are provided. Examples of *SCPs* would include surgeons (orthopedic, cardiovascular, vascular, etc.), cardiologists, oncologists, urologists, etc.

SPOUSE - *Subscriber*'s legal *spouse*.

SUBSCRIBER (you, your) - An employee of the *Group*, who resides and/or works in Indiana (the geographic area in which *ADVANTAGE* is licensed), who meets the eligibility requirements of the *Group*, who has enrolled for coverage with ADVANTAGE, and for whom *premiums* have been paid by the *Group*. A *subscriber* and *spouse* working for the same *Group* cannot be both *member* and *dependent.*

TERMINALLY ILL OR TERMINAL ILLNESS - A *physician* has given a prognosis that a *member* has six months or less to live.

URGENT CARE - Urgently needed services or *urgent care* services are instances when a *member* needs *covered services* urgently:

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

Urgently needed services are determined by medical condition not the place of treatment.

WELL CHILD CARE - A clinical check of a child for the purpose of assessing physical status and detecting abnormalities, in the absence of symptoms. *Well child care* includes pediatric immunizations including, but not limited to: diphtheria, pertusis, small pox, measles, mumps, rubella, poliomyelitis, and tetanus.

WOMAN AT RISK - A woman who meets at least one of the following descriptions:
- a woman who has personal history of breast cancer;
- a woman who has a personal history of breast disease that was proven benign by biopsy;
- a woman whose mother, sister, or daughter has had breast cancer; or

YOU or YOUR or MEMBER - An *eligible person* enrolled in *ADVANTAGE*'s health plan, as a *subscriber* or *eligible dependent.*

YOUNG ADULT – means a person who, regardless of marital status:
(1) between the ages of 19 and 24; and
(2) is not eligible for coverage as an eligible dependent under the subscriber contract; and
(3) meets one of the following criteria:
(A) is the natural or adopted child of a subscriber; or
(B) is the stepchild, grandchild, other blood relative of a subscriber and the subscriber pays more than 50% of the person's total support; or
(C) the subscriber is the persons' legal guardian and the subscriber pays more than 50% of the person's total support.

Family Planning Services Rider

The Certificate is amended as follows. If there is any conflict between the Certificate and this Rider, this Rider shall prevail. The effective date of this Rider is the date shown on the Contract.

Ethical and Religious Directives: ADVANTAGE Health Solutions, Inc.[sm] (ADVANTAGE) is an institution operated in accordance with The Ethical and Religious Directives for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. ADVANTAGE shall not be required to provide, and no provision of a Policy shall be construed so as to require it to provide, services that are inconsistent with the medical ethics or precepts of the Catholic Church.

Family Planning Services means:

1. birth control drugs that require a prescription
2. birth control devices that require a prescription, including the removal of such devices; and
3. voluntary sterilization

FAMILY PLANNING SERVICES

ADVANTAGE is owned by Catholic organizations. Because of this, ADVANTAGE cannot provide services that are not in accord with the Ethical and Religious Directives. Coverage for Family Planning services will be provided and claims will be administered through a 100% reinsurance program through:

Cyrca Insurance Management
303 Congressional Blvd.
Carmel, IN 46032
1-800-510-0225

50% coinsurance up to $2,500 lifetime maximum for all Family Planning Services except for prescription drugs for birth control. Prescription drugs for birth control are excluded from the lifetime maximum. The applicable copayment for prescription drugs for birth control is equal to the amount of the outpatient prescription drug copayment stated in the Certificate if member is entitled to pharmacy benefits.

EXCLUSIONS

1. Abortion, except when the life of the mother would be endangered if the fetus were carried to term.

2. Birth control drugs or devices that do not require a prescription. For example:

   a. condoms; and

   b. foams, jellies, or creams used to kill sperm.

3. Oral and injectable drugs which are used primarily for the purpose of treating infertility. (For example, Clomid, Metrodin, and Pergonal.)
4. Cyropreservation of ova, sperm, or fertilized eggs.

5. Any procedure which involves destroying human embryos.

6. Artificial insemination, except by the covered person's spouse.

7. Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), or in-vitro or in-vivo fertilization.

8. Use of a surrogate for any reason.

9. Treatment for infertility.

10. Oral drugs for the treatment of impotence.

Anthem®
Health. **Join In.**

HIP
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

Anthem Blue Cross and Blue Shield Healthy Indiana Plan℠

a health plan sponsored by the State of Indiana

WELCOME

Anthem Blue Cross and Blue Shield is one of the trusted providers for the Healthy Indiana Plan, a new health plan sponsored by the State of Indiana.

Sí necesita asistencia en español, usted puede solicitarla sin costo adicional contactando a su corredor o agente de cuidados de la salud. También puede visitar www.anthem.com/espanol.

02/10

Welcome to the Healthy Indiana Plan, from Anthem Blue Cross and Blue Shield.

Anthem Blue Cross and Blue Shield's Healthy Indiana Plan℠ (HIP) is a new, affordable health care program for uninsured adult Hoosiers. The program offers health benefits, including physician services, mental health services, and prescription drug coverage. The program is subsidized by the State of Indiana, and therefore, requires only minimal monthly contributions from the participant.

It's all about your health. So let's start there first.

Anthem's Healthy Indiana Plan was designed to help you get the medical care you need to stay healthy – at little or no cost to you. The plan covers preventive care services recommended by the U.S. Preventive Services Task Force, the American Cancer Society®, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The preventive care benefit includes screenings, immunizations and other services to detect medical conditions in advance and keep you healthier in the long run.

These services are fully covered when received from an in-network provider and the first $500 will not apply to your POWER Account. If any of these services are received for diagnostic purposes, for example, a colonoscopy when symptoms are present, the appropriate plan POWER Account will apply and available account dollars may be used to cover costs.

Frequency and age restrictions do not apply to preventive care services. This allows doctors to prescribe the preventive care services that are appropriate for you. (Note: Some immunizations are only FDA approved for certain genders and ages.) The following is an overview of the types of preventive services covered:

Required Preventive Services for Roll Over of POWER Account Funds

All members – annually:
Preventive Care Counseling Office Visit
Physical exam
Flu shot
Diabetes Screen

Males over 35:
Cholesterol Testing - annually

Females:
Over age 45 – Annual Cholesterol Testing
Age 40-50 – every 2 years Mammogram
Over age 50 – Annual Mammogram
All woman – Annual Pap Test

Immunizations:
Every 10 years - Tetanus, Diphtheria, Pertussis - 1 dose Td booster
(Refer to CDC Recommendations for further information)

All participants will have a Personal Wellness and Responsibility Account or "POWER Account." Participants use this account to pay for their first $1,100 of initial medical expenses. Your account contains your required monthly contributions, as well as the state's contribution, for a combined total of $1,100.

The Anthem Blue Cross and Blue Shield Healthy Indiana Plan will pay for your preventive services and up to $500 per benefit period will not be charged to your POWER Account. At the end of the year if all age and gender appropriate preventive services have been received, any amounts remaining in your POWER Account up to the entire account balance (including the state's portion) rolls over to the next benefit period. This means you will owe less for your health care in your second year. However, if you don't get your recommended preventive health services, only the unused amount you contributed will roll over to the next benefit period. The state's portion will go back to the state.

Take this chart with you to the doctor. Ask if you are up-to-date or if you need any other exams, tests, shots, or counseling.

Anthem Blue Cross and Blue Shield Healthy Indiana Plan

a health plan sponsored by the State of Indiana

You must obtain services In-Network. Non-Network services are not covered, except Emergency Care and Family Planning Services.

Plan Benefits Guide

	In-Network
Annual Maximum	$300,000
Lifetime Maximum	$1,000,000
POWER Account (The POWER Account is 12 consecutive months from the 1st of the month in which the policy is effective)	$1,100
Emergency Care Childless adult - $25 Adult parents - <100% Federal Poverty Level - $3 100-150% Federal Poverty Level - $6 151-200 Federal Poverty Level - $25	Paid from POWER Account first and then 100% coverage after co-pay where indicated. Non-caretaker members have co-pay of $25. Caretaker members have copay of $3, $6 or $25 (see ID Card) which is waived for true emergency. Note - You should call your primary doctor for advice before going to the emergency room if you are not sure it is a true emergency. You can also call the 24/7 Nurse Line at 1-866-800-8780 to talk to one of our nurses. Go directly to the emergency room if you are having chest pains, or any other symptoms of a possible life threatening or serious health situation.
Preventive Care Services: Office Visits such as annual physicals Routine care such as immunizations, flu shot and cholesterol test **Screening Services:** Mammograms, chlamydia screening, blood glucose screening, Pap Smears, PSA, digital rectal exams and lead screening **Colorectal Cancer Screenings:** Fecal Occult Blood Screening Flexible Sigmoidoscopy, colonoscopy or radiologic imaging **Smoking Cessation Counseling**	First $500 per benefit period not charged to POWER Account Remember you must have all of your required preventive services each benefit period in order for all of the balance in your POWER Account to roll over to the next year.
Family Planning Services	Paid from POWER Account first, then 100% coverage from Anthem. Includes contraceptives and sexually transmitted disease testing
Prescription Drugs Retail: 30 days supply	Paid from POWER Account first, then 100% coverage from your insurance benefits. Prescription drug benefits are administered by the State. Call 1-866-879-0106 for prior authorization of prescription medication. Generic drugs are required, if available.

You must obtain services In-Network. Non-Network services are not covered, except Emergency Care and Family Planning Services. There are many different Anthem provider networks - be sure to use providers in the Anthem Healthy Indiana Plan and Buy In Level 1 Network. Call our Member Helpline at 1-800-553-2019 for assistance or go to www.anthem.com/healthyindiana.

Plan Benefits Guide	
Human Organ and Tissue Transplant Services	Paid from POWER Account first, then 100% coverage from Anthem.
Inpatient Hospital Care **Outpatient Hospital Care** **Physician Office Visits** **Outpatient Diagnostic X-Rays/Lab Tests** Doctor's office visit/outpatient hospital visit **Inpatient and Outpatient Mental Health** **Medical Supplies, DME and Prosthetics** **Outpatient Therapy Services** Maximums per benefit period: Physical Therapy - 25 visits Occupational Therapy - 25 visits Speech Therapy - 25 visits **Ambulance** (Emergency transportation only. Non-emergency is not covered.)	Paid from POWER Account first, then 100% coverage from Anthem.
Maternity Care **Dental** **Vision**	Not Covered. It is easy for members who become pregnant to move to Hoosier Healthwise Package B for complete medical and maternity coverage. Just complete a Change Form and submit with proof of pregnancy to the state. You can re-apply to come back to the Healthy Indiana Plan after your pregnancy.

If you have questions, please call toll-free 1-800-553-2019.

POWER Account

With the Healthy Indiana Plan, you receive an annual allocation in your POWER Account for you to spend the way you want on covered health care expenses. The POWER Account is made up of contributions from you and from the state, and possibly from your employer. The funds in this account are used to cover the expenses that would normally be considered your deductible so this means under the Healthy Indiana Plan, you don't have any out-of-pocket costs that must go to a deductible. On the date your coverage becomes effective the state will place their annual commitment of funds into your POWER Account. The state will also determine how much you must contribute to the POWER Account and Anthem will send you a monthly bill for 1/12th of that amount during your enrollment in the plan. However, you get credit for the entire $1,100 on day one, that means on the day your coverage becomes effective, your POWER Account is fully funded even though your contributions will be collected over the next 12 months of your benefit period. The plan also includes Traditional Health Coverage – which helps protect you against further health care expenses. In addition, the Healthy Indiana Plan provides access to personalized health services and online tools to help you manage your health, health decisions and health care dollars. Go to www.anthem.com and sign up for MyAnthem.

All participants will have a Personal Wellness and Responsibility Account or "POWER Account". Participants use this account to pay for their first $1,100 of initial medical expenses. Your account contains your required monthly contributions, as well as the state contribution, for a combined total of $1,100.

POWER Account Contributions

Your Contribution:

- This is the portion of the POWER Account that you must pay. The state will determine this amount and you will pay 1/12th, in equal amount each month over the 12 month enrollment period, so at the end of the year you have met your contribution requirement. However you will receive credit for the entire annual amount on the date your coverage becomes effective so the funds will be available for paying claims for covered benefits that you receive. If you leave the plan early you must still pay the remainder of your portion of the POWER Account for the period you were enrolled.

State Contribution:

- The state will determine the amount you will pay and the state will then fund the remaining portion of the $1,100 that will be placed in your POWER Account.

Employer Contribution:

- Employers may choose to contribute up to 50% of the member's annual contribution to the POWER Account. This would then reduce the monthly amount you are required to pay. For information on the procedure and terms of the employer contribution, call the number on the back of your Healthy Indiana Plan ID card. The information will be sent to you and you can discuss it with your employer.

The Healthy Indiana Plan design is a modification of Anthem's Lumenos Consumer Driven Health Plan. The consumer driven health plans use the term Health Incentive Account (HIA) to describe a portion of the plan benefits and to explain where funds are made available to pay for covered services. You may see the term Health Incentive Account or HIA in this document and when you do, it will always mean the same thing as your POWER Account.

Most consumer driven health plans have a deductible. After the deductible is met, then the traditional insurance part of the Healthy Indiana Plan coverage will be used to pay for covered services received up to the annual benefit maximum or the lifetime maximum whichever occurs first. With the Healthy Indiana Plan your POWER Account amount has been set to a level that covers the entire deductible. The funds in the POWER Account will be used to pay for the cost of covered services the member receives during the plan year. So remember, when you see a reference to the deductible, the funds needed to meet your deductible are included in your POWER Account.

Q: How does the POWER Account work?

A: Here's how it works:

- First use your POWER Account funds to pay for covered medical expenses and prescriptions. The account dollars you use apply toward your plan's deductible.
- When you have used all the funds in your POWER Account, the traditional insurance part of the coverage begins and all covered services are paid at 100% except for the copay on emergency room services.
- The first $500 of preventive care services are paid by your insurance - they do not impact your POWER Account and there are no out-of-pocket costs to you, as long as you receive care from a provider that participates in the Healthy Indiana network (an in-network provider).
- All you need to do is present your identification card at time of service. The correct amount will automatically be deducted from your POWER Account when the claim is adjudicated.

Q. How do I make contributions to my POWER Account?

A. After you make your initial contribution, you may choose the best payment option for you. You have the choice between the following payment options:

- **Automatic Bank Draft** - If you choose this method, please submit the automatic bank draft form along with a blank voided check.
- **Check or Money Order** - Payments made by check or money order should be mailed to: Anthem BCBS, IN HIP, P.O. Box 105674, Atlanta, GA, 30348-5674. The remittance slip should be included in the envelope with the payment. Please include your account number in the memo section of the check or money order. If paying for multiple Healthy Indiana Plan members on the same check, a remittance slip should be included for each member.
- **Credit Card** - You must call customer service each time you wish to pay by credit card at **1-800-553-2019.**
- **Cash** - Cash payments are accepted IN PERSON for both the initial payment and monthly payments at the following National City Bank: Plaza Office, 101 West Washington St., Indianapolis, IN, 46255, 317-267-7906. PLEASE, DO NOT MAIL CASH. For more information about cash payments, please contact: Martha Moeller, Branch Manager or Eric Nicholson, Office Manager. As always, please remember to get a receipt of payment.

Q. WHAT IF I DON'T USE $1,100 OF SERVICES? WHAT HAPPENS TO THE MONEY IN MY POWER ACCOUNT?

A. At the end of the year, if you have received all age and gender appropriate preventive services, the entire account balance (including the state's portion) will roll over to the next benefit period. This means you will owe less for your health care POWER Account contribution for the next benefit period. However, if you don't get your recommended preventive health services, only the unused amount you contributed rolls over to the next benefit period. The state's portion will go back to the state.

Pregnant Women

No pregnancy related procedures are covered under HIP. If you become pregnant while a Healthy Indiana Plan Member, you will simply need to submit a Change Form and proof of pregnancy to transfer to Hoosier Healthwise Package B, where your pregnancy and all health care needs will be covered. You will need to provide evidence of pregnancy, per Indiana State requirements.

- All medical services for you, pregnancy and otherwise, will be covered by Package B of Hoosier Healthwise.
- Any POWER Account balances will be returned on a prorated basis.
- You may re-enroll in HIP following your pregnancy.

Anthem Blue Cross and Blue Shield serves Hoosier Healthwise Members in Indiana.

Hoosier Healthwise is a health program for Indiana children, pregnant women, and low-income families. Health care is provided at little or no cost to Indiana families enrolled in the program.

Anthem Features for Hoosier Healthwise Members

- Medical coverage, including vision and mental health
- Many doctors to choose from; AND changing doctors is easy
- Prescription drugs
- A special program for pregnant women
- Sports physicals for children with your assigned provider
- Well-Child visits and vaccines
- Transportation services

We're Nearby to Help

Anthem has community resource teams that help members:

- In their language.
- Find a doctor who speaks their language.
- Fill out forms.
- Connect to other services and free health classes in their area.
- By visiting them at their home, when they ask.

We Can Help in Many Ways

Along with our local community resource teams and phone support, Anthem offers:

- A 24-hour nurse help line to answer health questions, plus special nurses trained to talk to teens.
- Local classes and programs about healthy living, at no cost to members.
- Kits to teach kids how to eat well and stay active, at no cost to members.
- A helpful booklet for pregnant members, at no cost to them.
- A gift card for pregnant women who see their assigned doctor for a pregnancy checkup within 42 days after joining our health plan.
- A reward for new mothers who complete their postpartum visit with their assigned doctor 21 to 56 days after childbirth.
- A gift for getting your baby immunized and completing well-child doctor visits.

We're here to help!

Call 1-800-889-9949 to get information about the Hoosier Healthwise program.

NOTICE OF PRIVACY PRACTICES

Effective July 1, 2007

We can translate this at no cost. Call 1-866-408-6131; TTY 1-866-408-7188.

Podemos traducir esta información sin costo. Llame al 1-866-408-6131; TTY 1-866-408-7188.

Please read this carefully.

This notice tells you who can see your Health Information with your ok and who can see it without your ok. It also tells what rights you have to see and MANAGE your information.

Your health and financial information are personal and private. The law says that we must protect this information of our current and former members. We get information about you from the Office of Medicaid Policy and Planning and the Office of Children's Health Insurance Program after you become eligible and enroll in our health plan. We also get medical information from your doctors, clinics, labs, and hospitals so we can approve and pay for your health care. Federal law says that we must give you this notice to help you understand what our legal duties are and how we will protect your verbal, written, and electronic health information using these methods:

- Physical (files)
- Technical (passwords)
- Procedural (policies to make sure your records stay safe)

When is it OK for us to use and share your health information?

We can use and share your information without your OK in some cases. Here are some examples:

For Your Medical Treatment

- To help doctors, hospitals, and others get you the care you need

For Payment

- To share information with the doctors, clinics, and others who bill us for your care
- When we agree to pay for medical care or services before you get them

For Health Care Operations

- To help with audits, fraud and abuse programs, planning, and day-to-day work
- To review our programs and try to make them better

For Public Health Reasons

- To help public health officials stop the spread of disease or prevent an injury

To Others Acting for You

- If you tell us it is OK, we can share your health information with your family or a person chosen by you who helps with, or pays for, your health care
- If you cannot speak for yourself and it is best for you, we can share your medical information with someone who helps with, or pays for, your health care

Other Uses Allowed or Required by Law

- To help the police and other people who enforce the law
- To obey laws about reporting abuse and neglect
- To help the court when asked to do so
- To respond to legal documents
- To give information to health oversight agencies for actions such as audits or exams
- To help coroners, medical examiners, or funeral directors find out your name and cause of death
- To help when you have asked to give your body parts to science
- To use for research
- To prevent or lessen a serious threat to health and safety
- To help government officials for special government functions
- To give information to workers' compensation for a work-related illness or injury

We will get an OK from you in writing before we use or share your health information for reasons not listed in this notice. You may tell us in writing that you want to take back your OK to share information. We can't take back what we used or shared when we had your OK, but we will stop using or sharing your information in the future.

What are your rights?

- You can ask to look at your health information and get a copy of it. Keep in mind that we do not have a complete medical record about you. **If you want a copy of your complete medical record, you should ask your doctor or health clinic.**
- If you think that something is missing from, or wrong in, your health record that we have, you can ask us to make changes.
- You can ask us not to share your information in some instances. However, we do not have to agree to your request.
- You can ask us to mail health information to an address that is different from your usual address or to send the information to you in another way. We can do this for you if sending to your usual address may put you in danger.
- You can ask us to give you a list of the times (after April 14, 2003) that we have shared your health information with someone else. This will not include the times we have shared your information for the purposes of treatment, payment, health care operations, or certain other purposes.
- You can ask for a paper copy of this notice at any time, even if you asked for a notice by e-mail.

What are our responsibilities?

- By law, we must keep your health information private except as listed in this notice.
- We must give you this notice that explains our legal duties about privacy.
- We must follow what we have told you in this notice.
- We must agree, when you make reasonable requests and you are in danger, to send your health information to a different address or to send it in a way other than regular mail.
- We must tell you if we cannot agree when you ask us to limit how your information is shared.
- If state laws are more strict than the rules in this notice, we will follow those laws.

What if you have a complaint?

If you think that we have not kept our promise to protect your health information, you may complain to us or to the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Contact Information

If you have questions, complaints about our privacy rules, or want to apply your rights, please call us at **1-800-553-2019.**

We are here to help. If you still feel that we have not protected your privacy, you also may file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services.

We reserve the right to change this notice and the way we protect your health information. If that happens, we will tell you about the changes in a newsletter. We also will post them on our website at **anthem.com.**

As we told you in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use, and share nonpublic personal information (PI) as described in this notice.
Your PI tells us who you are and is often gathered in an insurance matter.

- We may use your PI to make judgments about your:
  - Health
  - Money
  - Character
  - Habits
  - Hobbies
  - Reputation
  - Career
  - Credit

- We may collect PI about you from other persons or groups such as:
  - Doctors
  - Hospitals
  - Other carriers

- We may share PI with persons or groups outside of our company without your OK in some cases.
- We will contact you if we take part in an action that would require us to give you a chance to opt out.
- We will tell you how you can let us know that you do not want us to use or share your PI for a given action.
- You have the right to access and correct your PI.
- We take safety measures to protect the PI we have about you.

You can ask for a state notice that is more detailed. Please call the Customer Care Center at 1-800-553-2019; TTY 1-866-408-7188.

Some definitions—so we're all on the same page.

POWER Account – (also referred to as the Health Incentive Account (HIA)) The Personal Wellness and Responsibility (POWER) Account is a funded account the Member may use to offset the cost of any Covered Services as they meet the benefit plan POWER Account. If available, Anthem will automatically use funds from the POWER Account to offset the member's responsibility under the POWER Account (except for required copayments). The POWER Account/HIA will be funded with post-tax dollars from the state and the Member and are not considered a Health Spending Account or any other type of tax-preferred health spending accounts under federal law. Based on the Member's income level, the state will determine the Member's required Contribution amount for the benefit period. Each year the Member is enrolled, the state will contribute the difference between the amount of the POWER Account and the Member's required annual Contribution amount. Monthly, the Member must send Anthem 1/12th of the Member's annual required Contribution amount. Failure of the Member to contribute the required monthly amount to the account in a timely manner will result in the Member's termination from the Plan. At the end of the benefit period, a portion or all of the unused funds in the POWER Account/HIA (the "roll over" amount) may be made available to offset the Member's required annual POWER Account/HIA Contribution for the next plan year. The roll over amount available to offset Contributions in the next year will be determined by the state based on the Member completing a defined and required set of preventive services for the Member's age and gender. Note that roll over amounts are not calculated until 180 days after the end of the benefit period to allow time for submission of claims. In the event your income level changes during the Benefit year, you are permitted to request a re-determination of your required annual POWER Account/HIA Contribution amount.

POWER Account Contribution(s) – Your Contribution for the Healthy Indiana Plan is the amount you are required to contribute to the POWER Account/HIA as described in the definition of POWER Account. That amount will be determined by the State of Indiana and 1/12th will be billed to you monthly. Failure of the Member to pay the billed Contribution will result in termination from the Healthy Indiana Plan. Following termination or disenrollment from this program, you may not re-enroll for a period of at least twelve (12) months from the date of termination or disenrollment.

A **copayment** is your portion of the cost for health care services received at a hospital emergency room. The co-pay amount is listed on your Anthem ID card (it is either $3, $6 or $25). If you are admitted as an inpatient from the emergency room you will not have to pay the co-pay. Also, if you are a caretaker member, you do not have to pay the co-pay if your medical situation meets the prudent lay person guidelines to be considered a true emergency.

A **drug formulary** is a list of medications that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness.
You are required to use medications on the formulary list unless your doctor requests an authorization for different medication by calling the number on the back of your ID card for pharmacy prior authorization.

Information about our Network Providers.

Using our network. You must use Anthem Healthy Indiana Plan and Buy In Level 1 network providers except for a true emergency in a hospital emergency room. You can also go to non-network providers for Family Planning services as long as they are contracted with the State of Indiana as a Medicaid provider.

Notice of provider arrangements. Your Participating Provider's agreement for providing covered services may include financial incentives or risk-sharing relationships which are based on utilization and quality of services. If you have any questions regarding such incentives or risk-sharing relationships, please contact Anthem or your provider.

Accessing Covered Services. Some services, or supplies, such as prescription drugs, require your doctor to receive an authorization from Anthem that defines and/or limits the conditions under which the service, or supply, will be covered to help you avoid any unnecessary out-of-pocket expenses. Other services, such as organ transplants, require your physician to certify, and for us to approve the service as medically necessary and the appropriate setting. Neither process is a guarantee of coverage.

Non-network provider. Charges from non-network providers will not be paid, except Emergency Room and Family Planning and prior authorized services. Providers not contracted with the Anthem Healthy Indiana Plan can bill you for their services. However, those providers contracted with the State of Indiana (IHCP) can not balance bill Healthy Indiana Plan members unless they specifically give you notice in advance that you will have to pay for the service. The notice must be specific and you must sign to agree to have the service knowing you will be responsible for paying the charge.

And now—some really important information you should take the time to read.

Our appeal rights and confidentiality policy.

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away when you first get an initial decision from us, but we require that you file within 30 days of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 20 days of receiving your first appeal. If you are denied coverage based on medical necessity or experimental/investigative exclusions, you can request that a board eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/investigative reasons, you can also appeal. Please call customer service or check your contract or certificate of coverage for more information on our internal appeal and external review processes. Unless our notice of decision includes a different address, send requests for a review of appeal to:

Anthem Blue Cross Blue Shield Healthy Indiana Plan
P.O. Box 6144
Indianapolis, IN 46209-9210

Medicaid Hearing and Appeal Process

If you have a problem with our appeal decision, you can ask for a Medicaid Hearing and Appeal Review. You may ask for a Medicaid Hearing and Appeal Review if we:

- Denied you a service
- Reduced a service
- Ended a service that was approved previously
- Failed to give you timely service

To ask for a review, you must send a letter to the state Medicaid agency within 30 business days of getting our decision about your appeal. Send your request to:

Indiana Family Social Services Administration
Hearing and Appeals Section, MS-04
402 W. Washington St., Room W392
Indianapolis, IN 46204-2773

An Administrative Law Judge will hear your case and send you a letter with the decision within 90 business days after the date that you first asked for a hearing.

How to avoid Balance Billing. We will work with you to protect you from being balance billed for services when you do not use a network provider as long as the provider is contracted with the state of Indiana as an Indiana Health Care Provider (IHCP). These providers can not bill you the difference between the amount we pay and their total charge: Since the only benefit that is available out of network (not including emergencies) is family planning it is important for you to contact customer service if you are seeking family planning services from a non-network provider; our customer service will work with you to identify a provider who has completed an Indiana Health Care Provider (IHCP) agreement so your covered family planning services can be provided and you will not be subject to balance billing; If, however, you do not call in advance and you use a provider who is not an IHCP or who is not a network provider then we can not prevent the provider you use from billing you for the difference between the provider charge and our maximum allowable amount.

Anthem®
Health. **Join In.**

HIP
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

This brochure is only a summary of benefits. It isn't part of the Healthy Indiana Plan Member Handbook. The Healthy Indiana Plan Member Handbook you will receive if you're approved for coverage includes all the details of the plan. In the event of a conflict between the information in this brochure and your Healthy Indiana Plan Member Handbook, the terms of your Healthy Indiana Plan Member Handbook will prevail. Read your Healthy Indiana Plan Member Handbook carefully. Anthem has the right to rescind, cancel or terminate your coverage based on provisions described in the Healthy Indiana Plan Member Handbook.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association.
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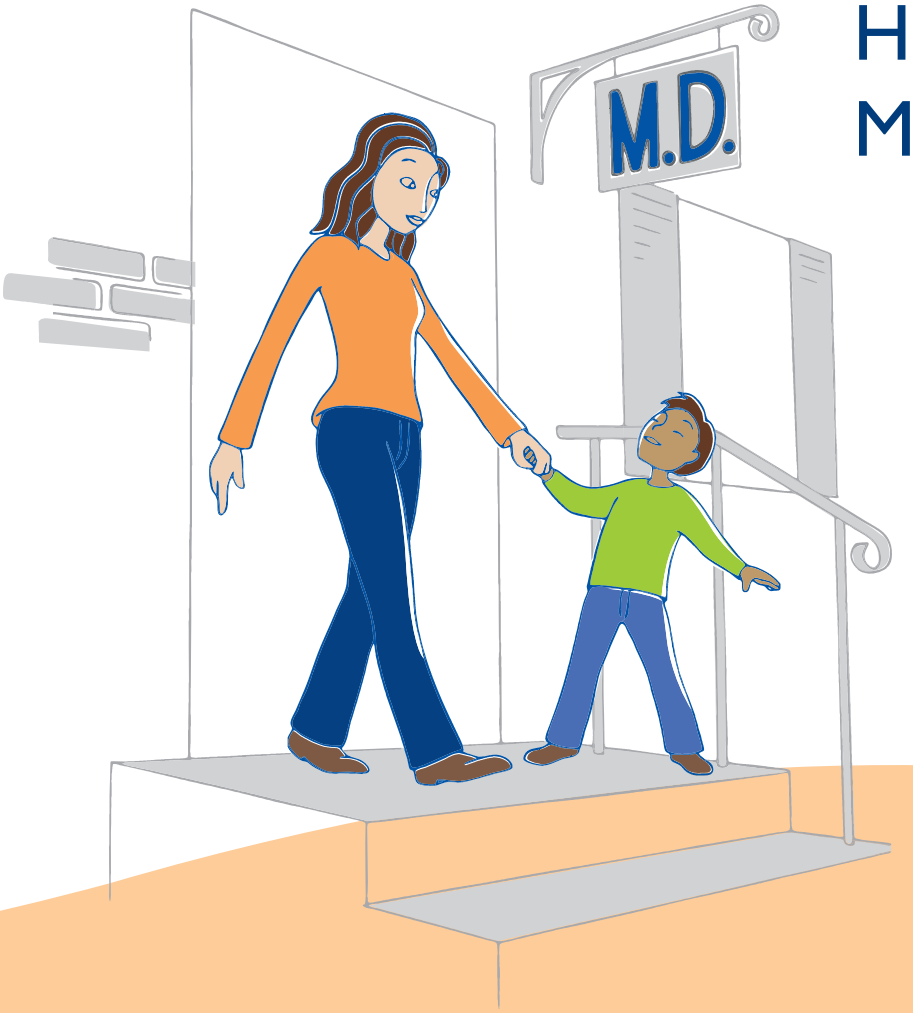
MDwise



Healthy Indiana Plan Member Handbook

HIP

HEALTHY INDIANA PLAN℠

Health Coverage = Peace of Mind

Welcome to MDwise!

Dear MDwise Member:
Welcome to the Healthy Indiana Plan! Your Healthy Indiana Plan is MDwise. You will get health care benefits from this plan.

Five Basic Rules

Now that you're a member, you should always follow these basic rules:

1. Carry your MDwise with you at all times. Show your card every time you get health care.
2. Contact your Primary Medical Provider for all medical care.
3. Only use the emergency room for true emergencies.
4. You must get preventive health care and check-ups each year that you have coverage.
5. You must pay your monthly contribution to stay in this health plan.

This handbook explains your benefits. Please call us with any questions.

Please read this handbook carefully.

Some pages have "**TIP**" boxes. These boxes have good advice to get the most out of your new benefits.

Call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196. There are representatives that can help you. If you should get an automated message after-hours, please leave your name and number and someone will return your call no later than the next business day. You can also visit **www.MDwise.org** for news and information.

Thanks!
Wishing You Good Health,
MDwise Customer Service Department

You Must Call Now to Activate Your Extra Benefits!

When you call, your customer service representative will:

- Welcome you to the MDwise plan and answer your questions.
- Tell you about your benefits.
- Tell you about special incentive programs and health programs.
- Ask you a few questions to find out about your health needs.
- Provide information about extra services besides health care, especially if you have special needs.
- Make sure that we have the correct address and phone number for you.

It will only take a few minutes, but it will help us to serve you better—and you'll learn about your plan BENEFITS! PLEASE CALL TODAY!

MDwise Customer Service Department: 1-877-822-7196 or in the Indianapolis area 317-822-7196.

Si quiere que le mandemos esta información en español, favor de llamar a nuestro departamento de Servicio al Cliente de MDwise al 1-877-822-7196 o en Indianápolis 317-822-7196. Gracias.

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PLEASE CALL THE MDWISE CUSTOMER SERVICE DEPARTMENT WITH ANY QUESTIONS ABOUT THIS HANDBOOK OR YOUR NEW BENEFITS 1-877-822-7196 or in the Indianapolis area 317-822-7196.

You can also visit the MDwise Web site: **www.MDwise.org.**

Welcome to MDwise!

HOW TO USE YOUR POWER ACCOUNT

As a member of the Healthy Indiana Plan, there are special rules to follow. Once you are eligible for the Healthy Indiana Plan, you will get a letter that will let you know what your monthly contribution is. You must pay this each month. If you do not pay this, you will be **disenrolled** from the program. We will send you a statement each month to remind you. If you are disenrolled due to non-payment, you cannot re-enroll for 12 months and there will be a 25% penalty on your POWER Account.

If a HIP member is disenrolled due to their death, MDwise will refund the POWER Account to the member's estate without penalty. This is done within 60 days of receiving notice of the member's death.

There are a number of ways you can make your monthly POWER Account contribution:

1. **Check or Money Order.** Make your check or money order payable to MDwise and mail your payment to:

   MDwise
   P.O. Box 713194
   Cincinnati, Ohio 45271-3194

   You can also pay by check or money order **in person** at:

   MDwise/ACS
   4550 Victory Lane
   Indianapolis, IN 46203

   Important note: All checks and money orders are held for 10 days to allow them time to clear. Please keep this in mind when mailing your contribution.

   If you do not have enough money in your bank account to cover the payment that you make, you will have an additional fee to pay. You will have to pay an $8.50 fee if your check bounces. This is in addition to making your monthly payment again.

2. **Cash.** Please do not mail cash. Cash, check or money order payments can be made **in person** at Key Bank locations, statewide. Please call Customer Service to find participating Key Bank branches, as all branches will NOT be participating.

   When paying by cash, you must have your initial payment letter or monthly invoice for payment to be accepted.

3. **Employer Contribution.** Ask at work if your employer is willing to pay part of your contribution. If so, your employer has to fill out the Employer Contribution Form. You can call Customer Service to give us the name and phone number of your employer. We will then contact your employer for you. Only a part of your contribution can be made by your employer. You will get a bill each month for the rest.

4. **Payroll Deduction.** Ask at work if your employer is willing to take your contribution from your check. If so, your employer has to fill out a Payroll Deduction Form. You can call Customer Service to give us the name and phone number of your employer. We will then contact your employer to get this set up.

For you to keep your Healthy Indiana Plan coverage, you must pay your POWER Account contributions by the due date on the bill you get each month. If your employer agrees to pay a part of your contribution, and then does not make that payment, we will let you know. You will then have 60 days to pay it yourself.

The Healthy Indiana Plan will add the rest of the funds that you will need to get health care services. This money will go into a POWER Account. POWER Account stands for Personal Wellness Responsibility Account. You will have $1,100 in your POWER Account. You will get a MDwise card in the mail. Use this MDwise card whenever you go to the doctor, the pharmacy or anytime that you get health care services. Except for your preventive care, other medical services will be paid for by your POWER Account. When the cost of your medical services is more than $1,100, MDwise will cover the costs.

This plan does have some limits. They are:

- $300,000 per year
- $1 Million dollars in a lifetime

HOW TO USE YOUR POWER ACCOUNT continued

It is important to remember that preventive care is covered. The Healthy Indiana Plan will cover all preventive care. Please see **Pages 7 and 8** for more information about the preventive care that you need to get. If you get the preventive services you need by the end of the year, and you have money left over in your POWER Account, that money will be rolled over to your POWER Account for next year! If you DO NOT get the preventive care that you need, any state contribution money left over at the end of the year will not roll over to the next year.

If you have any questions about your new POWER Account and to find out how much is in your account, please call MDwise Customer Service at 1-877-822-7196, or in the Indianapolis area 317-822-7196.

How to Know What Medical Service Cost Your POWER Account.

It is important to know what your medical services cost. That way you will know how much is going to be taken out of your POWER Account each time you get medical care. Please visit the MDwise Web site at **www.MDwise.org** for a list of medical services and their costs. You can also call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area, 317-822-7196, and we can mail you a list of services and their costs.

MDwise Healthy Indiana Plan Benefit Summary

Annual Maximum	$300,000
Lifetime Maximum	$1,000,000
POWER Account	$1,100
Emergency Care	$3–$25 member copay; Copay is not required if ER visit is a true emergency or if you are admitted
Preventive Care - annual check-ups; annual screenings recommended by your PMP and according to preventive care guidelines for your age and gender	MDwise pays at 100%
Family Planning	Paid from POWER Account; Then MDwise pays 100%
Prescription Drugs	Paid from POWER Account; Then State pays 100%
Inpatient Hospital Care Outpatient Hospital Care Physician Office Visits Outpatient Diagnostic X-rays and Lab Tests Inpatient and Outpatient Mental/Behavioral Health Medical Supplies, DME and Prosthetics Outpatient Therapy Services Ambulance (Emergency Transportation Only)	Paid from POWER Account; Then MDwise pays 100%
Organ and Tissue Transplant Services	Paid from POWER Account; Then MDwise pays 100%
Pregnancy Services, Dental, Vision	Not Covered
Out of Network Services (Except for Emergency Care and Family Planning)	Not covered

MEMBER REDETERMINATION

Healthy Indiana Plan members must re-enroll every 12 months. This is also called redetermination. The process will determine if you are still eligible. It will also determine what monthly amount that you need to pay for the next year.

90 days before your coverage ends, you will get a letter from the Division of Family Resources with information on how to enroll for next year. Please read this information VERY carefully! If you have questions about it, feel free to call us at 1-877-822-7196 or in Indianapolis, 317-822-7196.

60 days before your coverage ends, you will get another letter from the Division of Family Resources with a re-enrollment form. You must fill out this form completely and mail back to:

FSSA Document Center
P.O. Box 1630
Marion, IN 46952

You can also fax the completed form to: 1-800-403-0864.

It is very important that you fill out the re-enrollment form right away and send it in! The Division of Family Resources must get this completed form 45 days BEFORE your coverage term ends or you will be disenrolled from HIP. You will not be able to re-enroll for 12 months.

If you need help to fill out this form, please call us and we would be happy to help you! Also, if you do not get this form by 60 days prior to your re-enroll date, call 1-877-438-4479 to request a new one be sent to you.

GETTING MEDICAL SERVICES

You chose or were assigned to MDwise. Your MDwise doctor is called your Primary Medical Provider (PMP). PMPs can be one of four types of doctors:

- Family practice doctor
- General medicine doctor
- Internal medicine doctor
- Gynecologist doctor–for women only

Some PMPs work with trained health care assistants. The types of assistants that may help your PMP are:

- Nurse Practitioners
- Physician Assistants
- Medical Residents

These assistants can do many health care services that your doctor does. They can take medical histories, complete physicals, order lab tests, and give you health education.

If you would like to learn more about these assistants, or would like to see one of these assistants at your doctor's office, please call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

Your MDwise Doctor Will Handle All of Your Health Care.

This includes:

- Giving check-ups and immunizations (shots)
- Giving routine care
- Writing prescriptions
- Referring you to specialists or other providers
- Admitting you to the hospital

You should call your doctor whenever you need care.

Visit Your Doctor First

As a MDwise member, you must get most health care through your assigned doctor.
This way, your doctor can organize all your health care services. This helps you be as healthy as possible.

Always call your doctor when you need medical care. Your doctor has someone who can help you 24 hours a day.

If you get sick after hours, call your doctor's regular office number. If you hear a message, listen for instructions on what to do.

Sometimes, your doctor may want you to get care from other providers. When this happens, your doctor will give you a written okay. This will let you go to another doctor or to a hospital or lab. **This written okay is called a referral.** Your doctor will give you a referral to visit another MDwise doctor. If we do not have the doctor you need in MDwise, then we will find you a doctor outside of MDwise that can help you.

TIP:

New MDwise members should call to make an appointment with their doctor right away. Make an appointment with your new doctor in the first 3 months or 90 days. You should make an appointment even if you are not sick. You can ask to have a physical exam and talk to your doctor about any other preventive care that you need to get. This is also a good way to get to know your new doctor so he or she can take better care of you-before an emergency happens!

HOSPITALS

You may need to go to the hospital at some time. Your doctor will set this up for you. You should not go to the hospital without your doctor's okay. This is very important. Otherwise, MDwise may not cover your hospital care.

Choosing a Hospital

Your doctor only treats patients at a certain hospital. You should only use the hospital that your doctor uses. Ask your doctor first!

Examples of when you should use your doctor's hospital:

- When you have planned surgery
- When your doctor wants to admit you for other reasons

However, if you have a true emergency, you do not have to call your doctor. Just go to the nearest hospital for immediate care.

Remember that you must pay a copay when you use the emergency room.

TIP:
Ask your doctor which hospital to use before you need it. Always use that hospital, unless it is a true emergency. Then, just go to the closest hospital right away.

Special Situations

What Do I Do If There Is An Emergency?
You should call your doctor whenever you have questions or need care. This is the best way to help your doctor take care of you. However, if it is an emergency, do not wait to call your doctor first!

Call 911 or go straight to the nearest hospital emergency room.

You can read more about emergency care on **Page 13**.

What Do I Do When I Am Far From Home?
If you are far away from home, you should still call your doctor if you need care. He or she can help you get routine or urgent health care.

If you cannot afford the long distance call to your doctor, we can help. You can call MDwise free of charge. We will help you reach your doctor.

TIP:
Your doctor should be available 24 hours a day! You should always be able to reach your doctor or your doctor's after-hours number. It is okay to call, even late at night, if you have an emergency or urgent health care needs.

Interpretation Services

MDwise doctors can talk to you in Spanish or other languages. This is a free service. It is available to you 24 hours a day, 7 days a week by phone and at doctor visits. You or your doctor can call MDwise Customer Service and these services will be arranged for you.

STAYING HEALTHY

Get Check-ups Regularly

It is important to get check-ups from your doctor every year. This is true even if you feel healthy. There are many reasons to get preventive care check-ups. The information you will learn will help you take charge of your health!

Check-ups will help you:

- Get immunizations (shots) that can help keep you from getting sick.
- Catch early warning signs before a disease or illness gets worse.
- Check "vital statistics" so your doctor can compare them when you do get sick.
- Get advice on eating better, quitting smoking, or other healthy living tips.

TIP:

Regular check-ups help you and your doctor get to know each other. This will help your doctor understand your needs when you are sick! Regular visits will help you feel that you can trust your doctor about your health.

Preventive Care for Adults

Adults need several kinds of preventive care, like:

- Routine exams and tests, as your doctor recommends. This may include mammograms or prostate exams.
- Annual pelvic exams, Pap tests and breast exams for adult females.
- Flu shots.

PREVENTIVE CARE GUIDE

Preventive Care

The following chart lets you know what care or screenings you may need for someone your age and gender. For example, if you are a 25 year old female, please find that row for the preventive care that you may need. Your doctor will know what preventive services you need. For those members that started HIP in 2008 and are in their second year of coverage and for new members in 2009, the following chart shows you the preventive services that you need to get in order to roll-over your POWER Account balance at the end of the year.

IF YOU ARE:	YOU NEED:
Male age 19-34	Annual Physical Exam Blood Glucose Screen* Tetanus-Diptheria Screen
Female age 19-34	Annual Physical Exam Pap Smear Blood Glucose Screen* Tetanus-Diptheria Screen
Male age 35-49	Annual Physical Exam Cholesterol Testing* Blood Glucose Screen* Tetanus-Diptheria Screen
Female age 35-49	Annual Physical Exam Pap Smear Cholesterol Testing* (if you are over 45) Mammogram Blood Glucose Screen* Tetanus-Diptheria Screen
Male age 50-64	Annual Physical Exam Cholesterol Testing Blood Glucose Screen* Tetanus-Diptheria Screen Flu Shot*
Female age 50-64	Annual Physical Exam Pap Smear Cholesterol Testing* Mammogram Blood Glucose Screen* Tetanus-Diptheria Screen Flu Shot*

**Annual or as required by your disease/history specific condition*

Please remember that all preventive care that you get is covered by MDwise. This will not be taken out of your POWER Account. If you get preventive services every year, and you have money left over in your POWER Account, that money will be rolled over to your POWER Account for next year! If you **DO NOT** get the preventive care that you need, any state contribution money left over at the end of the year will not roll-over to the next year.

MAKING DOCTOR APPOINTMENTS

Call for an Appointment

You should always call before visiting the doctor's office. When you call, the doctor's staff will schedule a time for you to see the doctor as soon as possible.

Before You Call

When you need health care, you should call your doctor right away. When you call, you can also ask to talk to a nurse if you have medical questions.

Before you call, be sure that you:

- Have your MDwise Card handy
- Are ready to explain what is wrong
- Have a phone number where the doctor can call you later (this can be a family member or friend's number, if needed)
- Have a pen and paper ready to write down any instructions

TIP:
Always call at least 24 hours before your appointment if you have to cancel it. The doctor's office will set up a new appointment for you. Calling will also let the doctor's office know they can give your appointment time to someone else.

Schedule Your Appointment

This list shows the longest you should have to wait to get an appointment:

- Within 2 months for a first appointment.
- Within 1 day, for urgent care (like a fever).
- Within 3 days, for non-urgent care (like ongoing knee pain).
- Within 3 months for an annual physical exam.

It is very important to keep your doctor's appointments. This helps your doctor take better care of you!

Getting Ready for Your Doctor's Appointment

Before you see the doctor, be sure to write down your questions. Never be afraid to ask questions. The doctor wants you to understand all your treatment decisions.

TIP:
Please call MDwise at 1-877-822-7196 or in the Indianapolis area 317-822-7196 if you have problems with waiting times or making an appointment.

If this is your first appointment with a doctor, plan to arrive early. The doctor's office may have paperwork for you to fill out before you see the doctor.

In the Waiting Room

You will have the shortest wait in the waiting room if you make an appointment first. Your wait time should be under one hour. Sometimes it may take longer if your doctor has unplanned emergencies.

COVERED MEDICAL SERVICES

MDwise wants to help you stay healthy. That is why we cover preventive care as well as sick care. **If there are changes to your benefits, we will let you know by mail**. If you have any questions about your benefits, please talk to your doctor or call MDwise at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

Preventive Care

Getting regular preventive care is the key to better health. You get preventive care when you go to the doctor for check-ups and other well care. MDwise covers preventive care because it keeps you healthy and checks for problems before they become serious. Examples include:

- Check-ups and shots.
- Physical exams.
- Mammograms and Pap smears.

Necessary Care

Care must be "medically necessary." This means it is:

- Needed to diagnose or treat you.
- Proper based on current medical standards.
- Not more than what is needed.

Prior Authorization

Some services need approval from MDwise before you get them. This is called prior authorization. If your doctor does not get prior authorization when it is needed, MDwise will not pay for the services.

Prior authorization decisions are based only on the appropriateness of care and services. These decisions are also based on whether or not you have coverage. Doctors and staff that make prior authorization decisions do not get incentives or rewards for making these decisions. They do not get payment for deciding to deny a service or for making decisions that may make it harder to get care and services.

Services Your Doctor Must Approve and Refer You To

Members can get the full list of services on this page. Your doctor must approve all these services.

To get the following services, you must call or go to your doctor first. The doctor will refer you for any treatments you need:

Doctor Care:
Physical exams
Primary care
Preventive care
Specialty care

Hospital Care:
Inpatient services
Outpatient services
Diagnostic services
Lab tests and X-rays

Medical Supplies:
Prescriptions
Durable medical equipment
Hearing aids for 19 and 20 year olds

Other:
Immunizations (shots), health care screenings and diagnosis
Home health care therapy, including:
- Physical therapy
- Respiratory therapy
- Speech therapy
- Occupational therapy

Renal dialysis
Smoking cessation
Disease Management
Lead screening for 19 and 20 year olds
Hospice services
Skilled Nursing facility (60-day maximum)

If you have questions about your benefit package please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

SERVICES FROM OTHER DOCTORS

Sometimes, you may need to see a provider other than your regular doctor.

Seeing a Specialist

A specialist is a doctor who treats one part of the body, like the heart, skin, or bones. Your regular doctor will write you a referral if you need to see a specialist. That specialist will be in the MDwise network.

If MDwise does not have the doctor that you need in our network, or that is not within 60 miles of your home, we may authorize out-of-network doctors to take care of you. These providers must be Indiana Health Coverage Program or Medicaid providers.

You Must Get a Referral from Your Doctor Before Going to a Specialist.

MDwise will not cover specialist care unless you have a referral from your doctor. Your doctor will tell you how to get specialist care.

Self-Referral Services

The following services are "self-referral" services:

- Emergency services
- Family planning

MDwise covers these services. Your doctor can help you get these services, but you do not have to go through your doctor to get them. You can go to any provider, who is an Indiana Health Coverage Program or Medicaid provider, to get these services. Self-referral providers must get an okay from MDwise before giving you some services.

Remember, your doctor can best take care of you if you talk to the doctor before getting any kind of health care.

Services Not Covered

The following services are not covered under the Healthy Indiana Plan:

- Services that are not medically necessary
- Maternity and related services *(see page 12)*
- Dental Services
- Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly
- Vision services
- Elective abortions and abortifacients
- Non-emergency transportation services (i.e., transportation services that are unrelated to an emergency medical condition)
- Chiropractic manipulations such as back and spinal adjustments
- Drugs excluded from HIP
- Long term or custodial care
- Experimental and investigative services
- Day care and foster care
- Personal comfort or convenience items
- Cosmetic services, procedures, equipment or supplies, and complications directly relating to cosmetic services, treatment or surgery, with the exception of reconstructive services performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies or a previous medically necessary procedures
- Hearing aids (unless you are 19 or 20) and associated services
- Safety glasses, athletic glasses and sunglasses
- LASIK and any surgical eye procedures to correct refractive errors

- Vitamins, supplements and over-the-counter medications, with the exception of insulin
- Wellness benefits other than tobacco cessation
- Diagnostic testing or treatment in relation to infertility
- In vitro fertilization
- Gamete or zygote intrafallopian transfers
- Artificial insemination
- Reversal of voluntary sterilization
- Transsexual surgery
- Treatment of sexual dysfunction
- Body piercing
- Over-the-counter contraceptives
- Alternative or complementary medicine including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, massage therapy and herbal, vitamin or dietary products or therapies
- Treatment of hyperhydrosis
- Court ordered testing or care, unless medically necessary
- Travel related expenses including mileage, lodging and meal costs
- Missed or canceled appointments for which there is a charge
- Services and supplies provided by, prescribed by, or ordered by immediate family members, such as spouses, caretaker relatives, siblings, in-laws or self
- Services and supplies for which an enrollee would have no legal obligation to pay in the absence of coverage under the plan
- The evaluation or treatment of learning disabilities
- Routine foot care, with the exception of diabetes foot care
- Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot, and tarsalgia
- Any injury, condition, disease or ailment arising out of the course of employment if benefits are available under any Worker's Compensation Act or other similar law
- Examinations for the purpose of research screening

PREGNANCY CARE

The Healthy Indiana Plan does not cover pregnancy care. If you become pregnant while you are on the plan, please call MDwise Customer Service right away. All pregnancy services are covered under the Hoosier Healthwise Package B plan for pregnant women. You may be eligible for this plan. We can help you to sign up.

You must complete a "Report of Change" form and fax or mail to:

FSSA Document Center
P.O. Box 1630
Marion, IN 46952
Fax: 1-800-403-0864

You must also send proof of your pregnancy.

You will then be disenrolled from the Healthy Indiana Plan. At the end of your pregnancy, you can re-enroll in the Healthy Indiana Plan.

You can choose to stay in the Healthy Indiana Plan, but if you do this, your pregnancy services will not be covered.

Regular check-ups are important for a healthy baby so don't forget to call right away, so that you can get the care that you need! You can call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

EMERGENCY CARE

No one likes to spend hours in an emergency room. You can help by getting preventive care. This way, you can get health care before the problem gets too bad. See **Page 8** for a list of preventive care services that are right for you.

MDwise will cover emergency care 24 hours a day. If you have a true emergency, go to the closest hospital right away. MDwise will cover your emergency care even if:

- You are far away from home.
- You cannot get to your doctor's regular hospital.

Post-stabilization services in the emergency room are also covered. The emergency room doctor will stabilize the condition that you went to the ER for. If the doctor decides that you need more testing or services, he/she can contact MDwise to get approval for more tests or services. This happens only after you are stable and are no longer in immediate danger.

Emergency Room Copay

Healthy Indiana Plan members must pay a copay when you go to the Emergency room. The copay is based on your level of coverage. Your copay can be from $3 to $25. Your copay is listed on your MDwise card. You **cannot** use your POWER account to pay for this copay.

If you are admitted to the hospital after your emergency room visit, you do not have to pay this copay.

Three Kinds of Care

There are different kinds of health care: preventive care, urgent care, and emergency care. This chart shows you what to do when you need each kind of care. If you have questions, always ask your doctor for advice.

KIND OF CARE	WHAT TO DO
Preventive Care - This is when you get regular care to keep you healthy. Examples are: • Check-ups • Annual exams • Immunizations (shots) • Prescriptions and refills	**Preventive Care** • You should always call your regular doctor to make an appointment for preventive care.
Urgent Care/Sick Visit - This is used when you need immediate care, but you are not in danger of lasting harm or loss of life. Examples are: • Earache • Sore throat • Fever • Minor cut that may need stitches	**Urgent Care/Sick Visit** • Call your doctor. The doctor will make you an appointment or give you other instructions. • You should not go to the Emergency Room for urgent care. • Even if it is late at night, your doctor always has someone who can talk to you and help.

Emergency Care - This is used when you have a serious medical condition and are in danger of lasting harm or loss of life if you do not go to the Emergency Room immediately. Examples are:
• Poisoning
• Severe head injury
• Excessive bleeding
• Convulsions
• Serious burns
• Loss of consciousness
• Sudden severe chest pains
• Trouble breathing
	Emergency Care
	• Go to the nearest hospital or call 911. You do not have to call your doctor first in an emergency.
	• When you get to the hospital, or as soon as you are able:
	  • Show them your MDwise card
	  • Tell them you are a MDwise member
	  • Ask them to call your doctor within 24 hours

Out-of-Area Care

If you are far away from home, you can still get health care. Before getting care, you must call your doctor. You can also call MDwise for help at 1-877-822-7196 or in the Indianapolis area 317-822-7196. If you have a true emergency, do not call first. Go straight to the nearest hospital.

After Hours Care

Even after-hours, you can call the doctor's regular office number. If you hear a message, listen for instructions on what to do. Most MDwise doctors will have someone "on call" that will call you back to answer your questions.

Your MDwise Card lists numbers you can call when you need help.

When to Go to the Emergency Room

- You should not use the ER for anything but true emergencies!
- If you are not sure if it is an emergency, call your doctor for advice.
- Your doctor has someone who can help 24 hours a day. If you hear a recorded message when you call, listen carefully for instructions.

TIP:
Always keep your MDwise Card in your wallet or purse. That way, if you need help, you will have our phone numbers close at hand.

BEHAVIORAL AND MENTAL HEALTH SERVICES

Many people think mental or emotional problems are rare. In fact, they are common. A mental illness or emotional problem can affect thoughts and behavior. It can make it hard to cope with normal life routines.

Covered Services

If you think you may have a mental or emotional problem, it is important to remember there is help. MDwise covers behavioral health services for our members. These services include:

- Mental health
- Behavior problems
- Alcohol and drug abuse

MDwise members can choose a behavioral/mental health provider and set up appointments without a referral from a doctor. However, you should always talk to your doctor. He or she can help you find the right behavioral health provider.

You must choose a behavioral health provider within the MDwise network. There is a list of behavioral/mental health providers that you can choose from. To find a behavioral/mental health provider you can call MDwise Customer Service or go to **www.MDwise.org**.

If you have any questions about behavioral and mental health services, call MDwise at 1-877-822-7196, or call 317-822-7196 if you are in the Indianapolis area. When you call you will be asked to pick a number from a list of options. Listen carefully and pick **option #2** for "behavioral or mental health services". If you have a behavioral or mental health emergency, there is an option that you can pick and someone will help you right away.

We can answer your questions!

PHARMACY SERVICES

Medicines for MDwise members are covered. You can go to any pharmacy that accepts Indiana Medicaid. If you have pharmacy questions or problems, please call 1-800-457-4584 and choose option #2.

How the Prescription Benefit Works

When you need medicine, your doctor will write a prescription. You can take that prescription to the pharmacy.

There are no copays for your prescription medicine. Your medicines are paid for through your POWER Account.

Over the counter medicines or vitamins are not covered under HIP unless they are on the preferrred drug list (PDL). See below for more information about the PDL.

Prescription Medicine

The Healthy Indiana Plan covers necessary medicines. Your doctor must prescribe these medicines. It must be a medicine approved by the Food and Drug Administration (FDA).

The Healthy Indiana Plan gives your health care provider a tool called a preferred drug list. This helps him or her prescribe drugs for you. A preferred drug list is a list of some of the brand and generic medicines covered by the Healthy Indiana Plan. MDwise Healthy Indiana Plan members can call 1-800-457-4584 and choose option #2 to ask about medicines that are covered. If you have Internet access, you can go to **www.indianamedicaid.com** or to **www.indianapbm.com.** This drug list will also show you any of the over-the-counter medicine and vitamins that are covered.

There is also the Indiana Medicaid Pharmacy Services Member Handbook. It is available online at **www.indianamedicaid.com** under Pharmacy Services or you may call 1-800-457-4584, option #2, to have a copy mailed to you.

If you need help, you can call MDwise Customer Service for help at 1-877-822-7196 (toll-free) or 822-7196 in the Indianapolis area. You can also visit **www.MDwise.org** to find a list of pharmacies. Please click on “find a provider” and choose the IHCP pharmacy directory.

TRANSPORTATION

Healthy Indiana Plan members can get ambulance transportation for true emergencies. You should only call an ambulance when it is a true emergency. If you think your problem could cause lasting harm or loss of life, call 911.

TIP:

Since non-emergency transportation is not covered under the Healthy Indiana Plan, here are some other ideas for gettting a ride to your doctor appointment:

- Ask a family member or friend to take you.
- Find a bus route or other public transportation to take you.

Remember, you must pay for these types of transportation. MDwise does not cover them.

SPECIAL HELP

MDwise has several ways to help us talk with special needs members. Instructions are shown below.

Hearing and Speech Impaired Members

1. Call the Relay Indiana Service at 1-800-743-3333. You can also dial "711". This number can be used anywhere in Indiana.
2. Ask them to connect you to MDwise: 1-877-822-7196 or in the Indianapolis area 317-822-7196.

Language Assistance

1. MDwise has customer services representatives that can talk to members in other languages. Please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196.
2. The customer service representatives can also get an interpreter on the line if needed. The customer service representative and the interpreter will both help answer your questions.

Member Advocates

MDwise also has staff that can help you with difficult issues that you may have such as help in talking to your doctor, keeping appointments or finding other services, like a parent support group or help with food, housing or utility problems. These Member Advocates can help if you need suggestions or information about other services available in your community. We call this program HELPlink.

Advance Directives

Advance Directives are documents you can complete to protect your rights for medical care. It can help your family and doctor understand your wishes about your health care. You can:

- Decide, right now, what medical treatments you want or don't want.
- Give someone the power to act for you in a lot of situations, including your health care.
- Appoint someone to say yes or no to your medical treatments when you are no longer able.
- Inform your doctor, in advance, if you would or would not like to use life support systems, if ever necessary.
- Inform your doctor if you would like to be an organ donor.

These are the types of Advance Directives in Indiana:

1. Talking directly to your doctor and family
2. Organ and Tissue donation
3. Health Care Representative
4. Living Will Declaration or Life-Prolonging Procedures Declaration
5. Psychiatric advance directives
6. Do not Resusitate Declaration and order (out of hospital)
7. Power of Attorney

Advance Directives will not take away your right to make your own decisions. Advance Directives will work only when you are unable to speak for yourself.

MDwise cannot refuse care or discriminate against members based on whether they choose to have, or not to have, an advance directive. MDwise is required to follow State and Federal laws. Your MDwise doctor should document whether or not you have executed an advance directive in your medical record.

If you have concerns that a MDwise organization or provider is not meeting Advance Directive requirements, please call MDwise Customer Service.

SPECIAL MDWISE PROGRAMS FOR YOUR GOOD HEALTH!

MDwise has a number of extra programs for you and your family. They will help you get healthy and stay healthy. Special MDwise programs include:

NURSEon-call

Speak with a nurse 24 hours a day

Sometimes you have questions about your health. Just call our 24-hour phone line and speak with a nurse, not a recorded message. Call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196. Select option 3.

INcontrol

Learn to manage your asthma, diabetes or other chronic illness

WELLNESSchats

Fun, educational community events where you can learn about good health

HELPlink

Work with a member advocate who knows about health, school and community services

SMOKE-free

Get help kicking the tobacco habit

WEIGHTwise

Reach and maintain a healthy weight

If you have questions about any MDwise programs, call us at: 1-877-822-7196 or in the Indianapolis area 317-822-7196, or visit the MDwise Web site **www.MDwise.org**.

MDWISE CAN HELP

We want to answer all your questions about your new MDwise plan. If you have any complaints, we are here to help fix the problem. We want you to get the best health care and service possible.

There is a MDwise representative that can help you 8:00 a.m. to 6:00 p.m. (EST), Monday through Friday. After hours, you can leave a message and someone will call you back right away the next business day.

If you need your member handbook and other MDwise information in other ways let us know. Examples are if you need the information in larger print, Braille or on an audiocassette.

Please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196, if you have good or bad comments! You can also visit the MDwise Web site at www.MDwise.org. Click on the Healthy Indiana Plan.

The next few pages have tips on how to handle changes or questions you might have about MDwise or your doctor. Keep this booklet handy in case you need help with one of these situations.

TIP:
MDwise members have certain RIGHTS and RESPONSIBILITIES!
A list of these is on **Page 25** of this handbook.

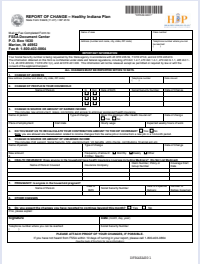
We want to provide high quality service to you. So, here is our promise to you:
- If you have a problem, we will be here to listen.
- We will do our best to fix the problem for you.

MAINTAINING YOUR MDWISE PLAN

New Address or Phone Number

If you move or change your phone number, you MUST call MDwise at 1-877-822-7196 or in the Indianapolis area 317-822-7196. You will need to fill out a "Report of Change" form. We can help you fill out this form.

"Report of Change" Form



REPORT OF CHANGE – Healthy Indiana Plan

Information About Reporting Changes For Healthy Indiana Plan

YOU MUST REPORT ALL CHANGES WITHIN 10 DAYS FROM THE TIME YOU KNOW ABOUT THE CHANGE

(Below are examples of changes you MUST report)

REPORT TO US

When someone MOVES IN or MOVES OUT of your home. When someone in your home gets married, is pregnant, has a baby, or dies. When someone is covered by health insurance. When a divorce is final by court order. When a child is placed in your home by a court or child support pay-pay changes.

REPORT TO US

Moving to Another State

When you MOVE

REPORT TO US

Change in a JOB, a new job, a job ends, an increase or decrease in your pay, or a change in your employer, or a change in MONEY received from Social Support or Social Security

FAILURE TO REPORT CHANGES MAY RESULT IN YOU HAVING TO REPAY BENEFITS

IF YOU HAVE QUESTIONS PLEASE CALL TOLL FREE 1-800-403-0864

Other Insurance Plans

If you have other health insurance, you must let us know. You are not eligible for the Healthy Indiana Plan if you have other health insurance. You must also tell us, and the Healthy Indiana Plan (1-877-438-4479), if:

- You have changes in your insurance
- You get hurt in a car wreck
- You get hurt at work
- You get hurt and someone else may have to pay

Changing Your Doctor

If you are not happy with your health care or your doctor, please call MDwise. We will work with you to fix any problems you have.

You are able to change your doctor once each year. You can only change for the following reasons:

- You have moved.
- Your doctor has moved or no longer belongs to MDwise.
- Your doctor does not return your calls.
- You have trouble getting the care you want or your doctor says you need.
- Your doctor was assigned by MDwise before you had the chance to choose a doctor for yourself.
- Other reasons–call for more information.

To change your doctor or to ask for a list of doctors in your area, please call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196 or visit **www.MDwise.org** to get a list of MDwise doctors.

Remember, it is better for your health to stay with one doctor, rather than to change doctors often.

Changing Your Plan

We hope that you are happy with the services that you receive from MDwise. If you are not happy please call MDwise Customer Service and we will try to help.

You can change your plan:

- At the end of the year when you re-certify for the Healthy Indiana Plan
- If you become eligible for the ESP plan
- If there are quality of care problems that we cannot fix for you

Changing Your Contribution Amount

If you have a change in family size or income, call 1-877-438-4479 (1-877-GET-HIP-9). Let them know about the change. You can also call MDwise Customer Service and we will help you complete a change form.

What To Do if You Pay More Than 5% of Your Annual Income

Are you on the HIP program as a caretaker adult? This means that you are on HIP and you have children that live with you that are on Hoosier Healthwise or Care Select. If you are and you have paid for healthcare services over 5% of your income, let us know.

This money must have been paid for:

- Monthly contributions
- ER copays

If what you have paid for these things is more than 5% of your income in a 12-month coverage period, you may not have to pay future contributions to HIP or ER copays.

If you think this is true for you:

- You must collect and send in copies of all of your receipts
- We must confirm your income

Requests and documentation can be sent to:

MDwise Customer Service
P.O. Box 44236
Indianapolis, IN 46244-0236

We will review all of your documents. We will confirm whether you have paid over 5% of your income during a 12 month coverage period. We will then let you know the outcome of our review. Call MDwise Customer Service for more information at 1-877-822-7196 or in Indianapolis 317-822-7196.

What To Do if You Get a Bill for Health Care

MDwise only pays your provider for the covered services you get. A provider cannot require you, your relatives, or others to pay additional charges for these covered services.

Health care providers generally cannot bill Healthy Indiana Plan members unless it is for a non-covered service.

If you do get a bill for health care services, take care of it right away by following the steps below. Otherwise, it may be sent to a collection agency.

- Contact your health care provider to make sure they know you are on the MDwise Plan.
- Contact MDwise and tell them you received a bill.

Providers know the limits placed on their services. The provider must tell you if MDwise does not cover a service before the service is provided. A provider may charge you for services that are not covered by MDwise if:

- The provider told you before providing the services that the services are not covered.
- You agreed to pay for the service in writing.

Remember to take your MDwise Card with you to all health care appointments and show it to the office staff.

Help MDwise Stop Fraud and Abuse

- Do not give your MDwise Card number to anyone. It is OK to give it to: your doctor, clinic, hospital, pharmacy or MDwise Customer Service.
- Do not let anyone borrow or use your MDwise Card
- Do not ask your doctor or any health care provider for medical care that you do not need
- Work with your primary doctor to get all of the care that you need
- Do not share your Healthy Indiana Plan or other medical information with anyone except your doctor, clinic, hospital, or other health provider

Call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196, if you have questions or concerns about fraud and abuse.

YOUR OPINIONS

Member Surveys and Outreach

Your opinions matter to us! We do a member survey to make sure you are happy. This helps us improve our service. It also helps us give better health care for you. This survey is done once each year.

MDwise members may occasionally receive phone calls from MDwise. One type of call might be to ask questions about your health needs. Your answers help MDwise know which programs might be right for you. Another type of call might be to ask about your satisfaction with your doctor. A MDwise caller will tell you right away who they are and why they are calling. Your answers to our questions help us serve you better.

MDwise also does automated calls. These calls may include reminders about monthly contributions or they might be a reminder to get needed preventive care.

If you have any questions at any time about these calls or the survey, please call: MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

MDWISE COMMITMENT TO QUALITY CARE

MDwise is always looking for new ways to improve your health and to serve you better. The Quality Program wants MDwise members to get high quality health care services. Health services that are safe and meet your needs are important to us.

We monitor your care and services throughout the year. Our Quality program looks at:

- Services given by doctors/providers
- Members being able to get the services they need
- Members getting the right number of services
- Results of our member satisfaction surveys

What we find from these reviews helps us to work closely with providers. Results also help us know what information to send to our members.

HOW TO GET HELP WITH A PROBLEM

Getting Help with a Problem

The quality of service you get from MDwise is important to us. If you have a concern, call the MDwise Customer Service Department at: 1-877-822-7196 or in the Indianapolis area 317-822-7196.

A MDwise customer service representative will file a grievance. The customer service representative will try to solve your concerns right away. If we cannot solve the issue by the next business day, we will follow up with a letter.

Filing an Appeal

If you do not agree with a decision you get, you have the right to ask for further review of the problem. This is called an "appeal." You can file an appeal about any health care decisions. Someone, like your doctor, can do this on your behalf if you want them to.

You must file an appeal within 30 days of the date that the decision was made. When you file an appeal, you may be able to continue getting a service that has been denied. This can only happen if you are getting those services already. You must send your appeal in before the denial takes effect. If MDwise decides that the services will not be authorized, you will have to pay for those services. Ask us about continued services if this is important to you.

How to File an Appeal:

Step 1. Submit Your Appeal

You must write a letter. You can call the MDwise Customer Service Department for help writing your letter. When you write a letter, you should include the following:

- Your name, address, telephone number, and MDwise card number.
- Date and description of the service that was denied
- Additional information that can help in our review
- You must sign the letter

Keep a copy of these papers for yourself.
Then, send us the original at:
MDwise Customer
Service Department
Attn: Appeals
PO Box 44236
Indianapolis, IN 46244-0236

Step 2. Wait for a Written Answer from MDwise

MDwise will review your appeal.
You will get a letter telling how we handled your problem. We will reply within 25 business days. If we need more time to review the problem we will write to you and let you know.

Step 3. MDwise Second Level Appeal Process

If you still do not agree with our answer, you can ask for an appeal by calling MDwise. You must also write us a letter to appeal. You have 30 business days to file an appeal. The MDwise Appeals Panel will review your problem. You can speak to the panel if you want. You can also have someone else speak for you. You will get a reply within 35 business days.

Step 4. Review by Independent Review Organization

If you are still not happy, you can sometimes ask for a review by an Independent Review Organization (IRO). The IRO will make a decision within 15 business days and MDwise will then notify you of the results.

Step 5. Appeal to FSSA

To appeal the IRO decision, you must contact the State. The Indiana FSSA Office of Hearings and Appeals handles this. You can write to them at:
Office of Hearings and Appeals, 402 West Washington, Room W392, Indianapolis, IN 46204. The FSSA decision is the final administrative ruling. If you are still not happy, you can file a lawsuit. A court will then review your case.

Other Notes: In an emergency, appeals will be handled quickly. This is called an "expedited" appeal. If your case can be expedited, we will review your case and notify you of a decision within 72 hours. Call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196 to see if this can be done.

YOUR RIGHTS AND RESPONSIBILITIES

MDwise provides access to medical care for all its members. We do not discriminate based on your religion, race, national origin, color, ancestry, handicap, sex, sexual preference, or age.

Medical care is based on scientific principles. We provide care through a partnership that includes your doctor, MDwise, other health care staff, and you – our member.

MDwise is committed to partnering with you and your doctor. We will:

- Treat you and your family with dignity and respect.
- Maintain your personal privacy. Keep your medical records confidential as required by law.
- Give you a clear explanation of your medical condition. You have a right to be part of all your treatment decisions. If you understand the options, you can better decide if you want a certain treatment Options will be discussed with you no matter what they cost or whether they are covered as a benefit.
- Provide you with information about MDwise, its services, and doctors.

In addition, YOU have the right to:

- Change your doctor once each year by calling the MDwise Customer Service Department.
- Timely access to covered services.
- Appeal any decisions we make about your health care. You can also complain about personal treatment you get.
- Get copies of your medical records or limit access to these records, according to state and federal law.
- Amend your medical records that we keep.
- Get information about your doctor.
- Request information about the MDwise organization and operations.
- Refuse care from any doctor.
- Ask for a second opinion.
- Make complaints about MDwise, its services, doctors, and policies.
- Get timely answers to your complaints or appeals.
- Take part in member satisfaction surveys.
- Prepare an advance directive.
- Get help from the Indiana Family and Social Services Administration (FSSA) about covered services, benefits, or complaints.
- Get complete benefit information. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered services.
- Request information about our physician incentive plan.
- Be told about changes to your benefits and doctors.
- Be told how to choose a different health plan.
- Health care that makes you comfortable based on your culture.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, in accordance with Federal regulations. This means that your doctor cannot restrain or seclude you because it is the easiest thing to do. The doctor cannot make you do something that you do not want to do. The doctor cannot try to get back at you for something that you may have done.
- When you exercise these rights, you will not be treated differently.
- Provide input on MDwise member rights and responsibilities.
- Participate in all treatment decisions that affect your care.
- If MDwise closes or becomes insolvent, you are not responsible for our debts. Also, you would not be responsible for services that were given to you because the State does not pay MDwise, or that MDwise does not pay under a contract. Finally in the case of insolvency, you do not have to pay any more for covered services than what you would pay if MDwise provided you the services directly.

YOU are responsible for:

- Contacting your doctor for all your medical care.
- Treating the doctor and their staff with dignity and respect.
- Understanding your health problems to the best of your ability and working with your doctor to develop treatment goals that you can both agree on.
- Telling your doctor everything you know about your condition and any recent changes in your health.
- Telling your doctor if you do not understand your care plan or what is expected of you.
- Following the plans and instructions for care that you have agreed upon with your doctor.
- Keeping scheduled appointments.
- Notifying your doctor 24 hours in advance if you need to cancel an appointment.
- Telling us about other health insurance that you have.

IMPORTANT TIP:
If you do not follow your doctor's advice, this may keep you from getting well. It is your job to talk with your doctor if you have any questions about your medical care. Don't ever be afraid to ask your doctor questions! It is your right!

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dear MDwise Member,
This notice tells about your privacy rights. You have rights about the medical information we keep about you. MDwise cares about your privacy. We protect your privacy rights. Please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196, if you have questions about this notice. You can ask to see a copy of the medical information we keep about you. When you call, ask for the Privacy Officer.
Wishing you good health,
MDwise

Summary of Privacy Practices

We may use and disclose your medical information, without your permission, for treatment, payment, and health care operations activities and, when required or authorized by law, for public health and interest activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your health care or payment for health care, and to appropriate public and private agencies in disaster relief situations.

We will not otherwise use or disclose your medical information without your written authorization.
You have the right to examine and receive a copy of your medical information, to receive an accounting of certain disclosures we may make of your medical information, and to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Organizations Covered by this Notice
This notice applies to the privacy practices of MDwise, Inc.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2008, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and send you a new notice within sixty (60) days of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

Uses and Disclosures of Medical Information

We will use and disclose medical information about you for treatment, payment, and health care operations. For example:
Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to determine eligibility, process claims, or make payment for covered services you receive under your benefit plan. Also, we may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include, for example, health care quality assessment and improvement activities and general administrative activities.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement. We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as a medical emergency or during disaster relief efforts.

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services and Appointment Reminders: We may contact you to remind you of appointments. We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services, that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our network, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and interest activities, judicial and administrative proceedings, law enforcement, research, and other public benefit functions:

- For public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- To avert a serious and imminent threat to health or safety;
- For health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- For research;
- In response to court and administrative orders and other lawful process;
- To law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- To coroners, medical examiners, funeral directors, and organ procurement organizations;
- To the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- As authorized by state worker's compensation laws.

Individual Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You must make a written request to obtain access to your medical information. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact us using the information at the end of this notice for information about our fees.

Disclosure Accounting: You have the right to a list of instances after January 1, 2008, in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before January 1, 2008. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact us using the information at the end of this notice for information about our fees.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. You may

obtain a form from that contact to make your request. Any agreement we may make to a request for restriction must be in writing signed by a person authorized to bind us to such an agreement.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of that health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Right to Obtain a Paper Copy: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: MDwise
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