Medical Benefit Booklet

Hitachi America Ltd.

CDHP HSA Core

Effective 01/01/2025

Administered by Anthem

BENEFIT BOOKLET

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de Servicio al Cliente que aparece en el reverso de su Tarjeta de Identificación.

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

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

The Plan provides the benefits described in this Benefit Booklet only for eligible Members and their eligible Dependents. The health care services are subject to the limitations, exclusions, Copayments, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously is replaced by this Benefit Booklet.

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

Your Employer has agreed to be subject to the terms and conditions of Anthem Blue Cross and Blue Shield's Provider agreements which may include Precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this Plan.

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

FL, GA and NH Select Network – This is a Preferred Provider Organization (PPO) Plan for all Members except residents of Florida, Georgia and New Hampshire; Members residing in those states are part of a Point of Service (POS) Plan, and must use the appropriate POS Network Provider in their respective states to receive Network benefits. If You are a Member in a state outside of Florida, Georgia and New Hampshire that participates in a Select Network arrangement, please call the Member Services number on Your Identification Card to locate participating Providers.

Verification of Benefits

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

Capitalized terms contained in this Benefit Booklet are defined in the section titled Definitions.

Misrepresentations

The Plan reserves the right to pursue all legal and equitable remedies against any person who, with intent to defraud or know that he/she is facilitating a fraud against the Plan, submits an application or files a claim

containing a false, incomplete, or misleading statement or otherwise provides false, incomplete, or misleading information to the Plan. Such person is subject to discipline up to and including termination of employment. The Plan Sponsor also reserves the right to require that any such person make the Plan whole. Without limiting the generality of the foregoing, if a person who is covered under the Plan (or someone seeking coverage on behalf of a person) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, the Plan reserves the right to rescind (i.e., retroactively cancel) coverage for the covered person.

Identity Protection Services

If You are enrolled in an Anthem medical Plan, You automatically receive a basic level of Identity Repair Services and can voluntarily enroll in Credit and Identity Theft Monitoring Services, at no cost to You. To learn more about these services, please visit https://anthemcares.allclearid.com/**.**

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MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have rights and responsibilities when receiving health care. As Your health care partner, the Claims Administrator wants to make sure Your rights are respected while providing Your health benefits. That means giving You access to the Claims Administrator's network health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition no matter what the cost or whether it is covered under Your Plan.
- Work with Your Doctors to make choices about Your health care.
- Be treated with respect and dignity.
- Expect the Claims Administrator to keep Your personal health information private by following the Claims Administrator's privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health Plan and share Your feedback. This includes information on:
  - The Claims Administrator's company and services.
  - The Claims Administrator network of health care Providers.
  - Your rights and responsibilities.
  - The rules of Your health Plan.
  - The way Your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care You receive.
  - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care You may get in the future. This includes asking Your Doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give the Claims Administrator, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your Identification Card.

The Claims Administrator wants to provide high quality Member Services to our Members. Benefits and coverage for services given under the Plan are governed by the Employer's Plan and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance

Anthem is committed to communicating with our members about their health Plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our Member Services Call Centers. Simply call the Member Services phone number on the back of Your ID Card and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Plan. See the Definitions and Claims Payment sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.
To get the highest benefits at the lowest Out-of-Pocket cost You must get Covered Services from a Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When You use an Out-of-Network Provider You may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please refer to the **Claims Payment** section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Welcome to the Health Savings Account (HSA) Plan!

The HSA plan administered by the Claims Administrator is an innovative approach to health benefits for eligible Employees of Hitachi America, Ltd. (the company).

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

How the HSA Plan Works

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

The HSA Plan – In Brief

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

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

Plus – To help You stay healthy, use:

Preventive Care
100% coverage for nationally recommended services using Network Providers.

No deductions from the HSA or Out-of-Pocket costs for You as long as You receive Your preventive care from a Network Provider. If You choose to go to an Out-of-Network Provider, Your Deductible or Traditional Health Coverage benefits will apply.

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

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

Choice of Providers

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

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

With the Plan, You have the flexibility to see any licensed health care provider You choose. The level of Your health coverage under the Plan depends on whether You use Providers who offer Network discounts or Providers who do not offer Network discounts.

Financial Tools

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

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

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

Contributions to Your HSA

Contributions to Your HSA	
Individual Coverage	$4,300
Family Coverage	$8,500

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

Annual Deductible Responsibility:

Deductible	**Network**	**Out-of-Network**
Individual Coverage	$2,750	$5,500
Family Coverage	$5,500	$11,000

Note: The Out-of-Pocket Maximum includes all Deductibles and/or Coinsurance You incur in a Benefit Period. Once the Family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Family for the remainder of the Benefit Plan Year. The Out-of-Pocket Maximum does NOT include Precertification penalties, or charges in excess of the Maximum Allowed Amount or for Non- Covered Services.

Traditional Health Coverage
The Plan pays:

Coinsurance

Traditional Health Coverage Coinsurance	Network	Out-of-Network
The Plan Pays	80% of the Maximum Allowed Amount	60% of the Maximum Allowed Amount
Your Coinsurance Responsibility	20% of the Maximum Allowed Amount	40% of the Maximum Allowed Amount

Out-of-Pocket Maximum

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

Additional Protection:
For Your protection, the total amount You spend for Out-of-Pocket is limited. Once You spend that amount, the **Plan pays 100% of the cost for Covered Services** for the remainder of the Plan year.

Annual Out-of-Pocket Maximum	Network	Out-of-Network
Individual Coverage	$5,950	$11,900
Individual on a Family Contract	$6,850	$11,900
Family Coverage	$11,900	$23,800

Schedule of Benefits	Network Member Pays:	Out-of-Network Member Pays:
Unless otherwise noted, Network and Out-of-Network services are subject to Deductible and Coinsurance. Coinsurance is based on the Maximum Allowed Amount.		
Allergy Care		
• Testing – Physician or specialist Physician	20%	40%
• Treatment – Physician *****Copayment/Coinsurance	20%	40%
• Treatment – specialist Physician *****Copayment/ Coinsurance	20%	40%
• Serum and allergy shots (Network not subject to the calendar year Deductible) – Physician or specialist Physician	20%	40%
Behavioral Health Care - Outpatient	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Coverage for the diagnosis and treatment of Behavioral Health Care conditions on an Inpatient or Outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet to the extent required by federal law.		
Clinical Trials Please see Clinical Trials under Benefits section for further information.	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Dental & Oral Surgery/TMJ Services		
• Accidental Injury to natural teeth (limited to treatment started within 6 months of an Injury to sound, natural teeth and treatment must be completed within 12 months of the Injury) • Oral Surgery • TMJ - Subject to Medical Necessity – excludes appliances and orthodontic treatment	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

Schedule of Benefits	Network Member Pays:	Out-of-Network Member Pays:
Unless otherwise noted, Network and Out-of-Network services are subject to Deductible and Coinsurance. Coinsurance is based on the Maximum Allowed Amount.		
Diagnostic Physician's Services		
Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:		
• Primary Care Physician	20%	40%
• Specialist Physician	20%	40%
• Diagnostic X-ray and Lab – office or independent lab	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Care, Urgent Care, and Ambulance Services		
Emergency room for a Medical Emergency	20%	Benefits are paid In-Network level at billed charges
Non-emergency use of the emergency room	20%	40%
Urgent Care clinic visit	20%	40%
Ambulance Services (when Medically Necessary)	20%	Benefits are paid Land/Air at billed charges

Note: Care received Out-of-network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.

As described in the **Consolidated Appropriations Act of 2021 Notice** in the Health Benefits Coverage Under Federal Law section of this Benefit Booklet. For Emergency Services Out-of-Network Providers may only bill You for any applicable Copayments, Deductible and Coinsurance and may not bill You for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined You are stable and followed the notice and consent process.

Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Refer to the Health Care Management-Precertification section for more information.

Note: If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. For

air Ambulance Services, Out-of-Network Providers cannot bill You for more than Your applicable Network Deductible, Coinsurance, and/or Copayment		
Schedule of Benefits	**Network Member Pays:**	**Out-of-Network Member Pays:**
Unless otherwise noted, Network and Out-of-Network services are subject to Deductible and Coinsurance. Coinsurance is based on the Maximum Allowed Amount.		
Eye Care • Office visit – medical eye are exams (treatment of disease or Injury to the eye) ► Primary Care Physician Coinsurance ► Specialist Physician Coinsurance • Treatment other than office visit	 20% 20% 20%	 40% 40% 40%
Gene Therapy • Precertification required	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Hearing Care • Office visit – Audiometric exam/hearing evaluation test ► Primary Care Physician Coinsurance ► Specialist Physician Coinsurance • • Cochlear Implants • Hearing devices hearing aids – Hearing aids are covered up to $2,500 once every 36 months. Routine hearing exams are not a Covered Service for age 19 and over.	 20% 20% 20% 20%	 40% 40% 40% 40%
Home Health Care Services Includes Home Infusion Therapy; and Private Duty Nursing (pre-certification is required)	20%	40%
Hospice Care Services	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

Hospice lifetime maximum	Unlimited	
Hospital Inpatient Services – Precertification Required		
• Room and board (Semiprivate or ICU/CCU)	20%	40%
• Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical Therapy, etc.)	20%	40%
• Pre-Admission testing	20%	40%

Schedule of Benefits	**Network Member Pays:**	**Out-of-Network Member Pays:**
Unless otherwise noted, Network and Out-of-Network services are subject to Deductible and Coinsurance. Coinsurance is based on the Maximum Allowed Amount.		
• Physician Services:		
► Surgeon	20%	40%
► Anesthesiologist		
► Radiologist		
► Pathologist		
Pay all radiologist, anesthesiologist and pathologist (RAPs) at Network level - *Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) at billed charges when providing **Network** Inpatient services**. If an Out-of-Network Provider is used at an Out-of-Network facility, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges**.		

Maternity Care & Other Reproductive Services (includes Dependent daughter) • Physician's office:	20%	40%
Global care (includes pre-and post-natal, delivery) • Primary Care Physician (includes obstetrician and gynecologist) Coinsurance • Specialist Physician Coinsurance • Midwife (Precertification required)	20% 20% 20%	40% 40% 40%
Physician Hospital/Birthing Center Services (Precertification required) • Physician's services • Newborn nursery services (well baby care) • Circumcision		
• **Note:** Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified		

Schedule of Benefits	**Network Member Pays:**	**Out-of-Network Member Pays:**
Unless otherwise noted, Network and Out-of-Network services are subject to Deductible and Coinsurance. Coinsurance is based on the Maximum Allowed Amount.		
Infertility Services $7,500 Lifetime Maximum Combined with RX For Infertility including Infertility Testing, artificial insemination and invitro fertilization. • ***Note: Please see Infertility Services Under Benefits section of this booklet for additional information.**	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Sterilization Services (Precertification required for Inpatient procedures. Reversals are not covered.) • Tubal ligation • Vasectomy Reversal of sterilization is not covered.	20%	40%

Medical Supplies and Equipment		
• **Medical Supplies**	20%	Benefits are paid at the Network level at 340% of CMS National Medicare
• **Durable Medical Equipment** Wigs & Toupees are covered for the initial purchase directly related to chemotherapy or radiation treatment.	20%	40%
• **Orthotics** Foot and Shoe No coverage for routine foot care, weak, strained, flat feet and non-surgical treatment of nails, bunions, calluses unless due to metabolic or peripheral vascular disease. Foot care for services with the diagnosis of diabetes is covered.	20%	40%
• **Prosthetic Appliances** (external)		
Nutritional Counseling	20%	40%
Outpatient Hospital/Facility Services		
• Outpatient facility	20%	40%
• Lab and x-ray services	20%	40%
• Outpatient physician services	20%	40%

Schedule of Benefits	Network Member Pays:	Out-of-Network Member Pays:
Unless otherwise noted, Network and Out-of-Network services are subject to Deductible and Coinsurance. Coinsurance is based on the Maximum Allowed Amount.		
Physician Services (Home and Office Visits) • Primary Care Physician Copayment (per visit) • Specialist Physician Copayment (per visit)	20%	40%
Office Surgery	20%	40%
Online Visits from LiveHealth Online Provider	20%	Out-of-Network and non-Live Health Online Providers – Not Covered
Prescription Injectables/Prescription Drugs For Prescription Drug coverage, refer to the Hitachi Prescription Drug Booklet for full details.	Not Covered	Not Covered
Preventive Services (regardless of Provider or setting where Preventive Services are provided)	Plan pays 100% of Maximum Allowed Amount	40%
Skilled Nursing Facility (Pre-certification is required) Maximum days	20% Unlimited per calendar year combined In-and Out-of-Network	40%
Surgical Services • **Gastric Bypass/Obesity Surgery** When Medically Necessary. Precertification Required	20%	40%
• **Abortion (Therapeutic and Voluntary Termination of Pregnancy)** **Abortion Travel and Lodging information, please refer to Travel Reimbursement Section**	**20%**	**40%**
Chiropractic Care	20%	40%
Acupuncture Maximum amount for per Plan Year is $1000 combined In & Out- of-Network. Deny all services billed once maximum has been reached..	20%	40%

Schedule of Benefits	Network Member Pays:	Out-of-Network Member Pays:
Unless otherwise noted, Network and Out-of-Network services are subject to Deductible and Coinsurance. Coinsurance is based on the Maximum Allowed Amount.		
Therapy Services (Outpatient)	**20%**	**40%**

- **Physical Therapy**
- **Occupational Therapy**
- **Speech Therapy**
- **Radiation Therapy**
- **Cardiac Rehabilitation**
- **Chemotherapy**
- **Respiratory Therapy**
- **Vision Therapy**

Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.

Benefits	Network Member Pays	Out-of-Network Member Pays
Transplant Services		
Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy. **The Center of Medical Excellence requirements do not apply to** cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **Note:** Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.) **Centers of Medical Excellence (CME) Transplant Providers** **Blue Distinction Center Facility**: Blue Distinction Facilities have met or exceeded national quality standards for care delivery. **Centers of Medical Excellence (CME)**: Centers of	**Center of Medical Excellence/Network Transplant Provider**	**Out-of-Network Transplant Provider**

Medical Excellence facilities have met or exceeded quality standards for care delivery. **Network Transplant Provider**: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. **Out of Network (PAR) Transplant Provider**: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.		
Benefits for Covered Services that are not part of the covered procedure will be based on the setting in which Covered Services are received. Please refer to the **Benefits** section for additional details.		
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.	The later of 30 days or date of discharge following a Covered Transplant Procedure at an Out-of-Network Transplant Provider Facility.
Covered Transplant Procedure • Care coordinated through a Network Transplant Provider/ Center of Medical Excellence – not subject to Deductible • When performed by Out-of-Network Transplant Provider (subject to Deductible, charges do not apply to the Out-of-Pocket Maximum). **You are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.**	20%	40%
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)	20%	40%
• Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)	Covered, as approved	40%

• **Eligible Travel and Lodging –subject to Claims Administrator's approval.** Lodging Allowance $50 for double occupancy	Plan pays 100% of Maximum Allowed Amount when a Blue Distinction Center for Transplants (BDCT) provides the services.	40%
• **All Other Covered Transplant Services**	Benefits are paid based on the setting in which Covered Services are received	40%

Abortion Travel Reimbursement — $2,500 Maximum Per occurrence — Not Covered

Travel and Lodging Expenses related to voluntary termination of pregnancy (i.e., abortion).

Unless prohibited by law, the Claims Administrator will cover reasonable and necessary travel costs when You are required to travel to another state to obtain Covered Services that are not available within Your state. The Plan will assist the patient and family with travel and lodging arrangements, when the Member lives in a state whose statutory laws limit the access to these services within state borders. Services must be received at a Network Facility. Deductible and other cost-shares may apply for travel and lodging benefits. Please contact Member Services at the number on the back of Your Identification Card to confirm Your benefits. Expenses for travel and lodging for the recipient and a companion are available as follows:

- Transportation is covered, including expenses for personal car mileage at the current Federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the abortion for an evaluation, the procedure, or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 per double occupancy per night is paid toward lodging expenses; meals are not covered).
- Travel and lodging expenses are available only if the Member resides in a state where they can't obtain these services and must travel to a Network Facility where services are received.
- If the patient is a Covered Dependent minor child, the transportation expenses of two companions will be covered; lodging expenses will be reimbursed at the $50 per-diem rate per double occupancy.
- These benefits are subject to a combined overall lifetime maximum of $2,500, per occurrence, for all transportation and lodging expenses incurred by the abortion recipient and companion (companions if the Covered Dependent is a minor) and reimbursed under the Plan.
- For information about the transportation and lodging benefits, please contact Member Services at the number on the back of Your Identification card.

The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Total Health and Wellness Solution

Building Healthy Families

This digital program can help support Your family from preconception through the stages of pregnancy, childbirth, and early childhood (to age 5 and beyond). It is available 24/7 through our Sydney Health mobile app, and at www.anthem.com, and features an extensive content library covering topics to support diverse families, including single parents and same-sex or multicultural couples. In addition, the app features many tools including fertility, diaper change, and feeding trackers, due date calculators, and blood pressure monitoring. Visit the Sydney Health app or www.anthem.com to enroll today.

24/7 NurseLine

You may have emergencies or questions for nurses around-the-clock. 24/7 NurseLine provides You with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, You can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting and refer You to programs and tools appropriate to Your condition.
- Bilingual RNs, language line and hearing impaired services.
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison control and pediatric Members with needs identified as either emergent or urgent.
- Referrals to relevant community resources.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep You and Your bank account healthier. Here's how it works: The Claims Administrator reviews Your incoming health claims to see if we can save You any money. The Claims Administrator can check to see what medications You're taking and alert Your Doctor if we spot a potential drug interaction. The Claims Administrator also keeps track of Your routine tests and checkups, reminding You to make these appointments by mailing You a MyHealth Note. MyHealth Notes summarize Your recent claims. From time to time, the Claims Administrator offers tips to save You money on prescription drugs and other health care supplies.

Carelone Imaging Cost & Quality Program

The Plan Sponsor has selected this innovative Imaging Cost & Quality Program for Members through AIM Specialty Health. This Program provides You with access to important information about imaging services You might need. The Program is not a benefit under Your health benefit plan.

If You need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where You go to receive the service. Sometimes the differences are significant – anywhere from $300 to $3000 – but a higher price doesn't guarantee higher quality. If Your benefit plan requires You to pay a portion of this cost (like a Deductible or Coinsurance) where You go can make a very big difference to Your wallet.

That's where the AIM Imaging Cost & Quality Program comes in – AIM does the research for You and makes it available to help You find the ***right*** location for Your MRI or CT scan. Here's how the Program works:

- Your Physician refers You to a radiology Provider for an MRI or CT scan;

- AIM works with Your Physician to help make sure that You are receiving the right test – using evidence-based guidelines;
- AIM also reviews the referral to see if there are other Providers in Your area that are high quality but have a lower price than the one You were referred to;
- If AIM finds another Provider that meets the quality and price criteria, AIM will give You a call to let You know; and,
- You have the choice – You can see the radiology Provider Your Physician suggested OR You can choose to see a provider that AIM tells You about. AIM will even help You schedule an appointment with the new Provider.

The AIM Imaging Cost & Quality Program gives You the opportunity to reduce Your health care expenses (and those of Your Employer) by selecting high quality, lower cost Providers or locations. No matter which Provider You choose, there is no effect on Your health care benefits. This program is intended to give You information that helps You to make informed choices about where to go when You need care.

Autism Spectrum Disorders (ASD) Program

The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a Member who has a diagnosis of ASD. Anthem provides specialized case management services for Members with autism spectrum disorders and their families. The Program also includes precertification and Medical Necessity reviews for Applied Behavior Analysis, a treatment modality targeting the symptoms of autism spectrum disorders.
For families touched by ASD, Anthem's Autism Spectrum Disorders Program provides support for the entire family, giving assistance wherever possible and making it easier for them to understand and utilize care, resulting in access to better outcomes and more effective use of benefits. The ASD Program has three main components:

Education

- Educates and engages the family on available community resources, helping to create a system of care around the Member.
- Increases knowledge of the disorder, resources and appropriate usage of benefits

Guidance

- Applied Behavior Analysis management, including clinical reviews by experienced licensed clinicians. Precertification delivers value, ensuring that the Member receives the right care, from the right Provider, at the right intensity.
- Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning, and referrals.
- Assure that parents and siblings have the best support to manage their own needs.

Coordination

- Enhanced Member experience and coordination of care.
- Assistance in exploration of medical services that may help the Member, including referrals to medical case management.
- Licensed Behavior Analysts and Program Managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic child.

Sydney Health

Discover a powerful and more personalized health app. View all Your benefits and access wellness tools to improve Your overall health with the Sydney Health app.

The Sydney Health mobile app works with You by guiding You to better overall health — and for You by bringing Your benefits and health information together in one convenient place. Sydney Health has everything You need to know about Your benefits, so You can make the most of them while taking care of Your health.

Working with You

- Reminding You about important Preventive Care needs

- Guiding You with insights based on Your history and changing health needs
- Empowering You with personalized tools to find and compare healthcare Providers and check costs

ELIGIBILITY

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

Coverage for the Eligible Employee

This Benefit Booklet describes the benefits an Eligible Employee may receive under this health care Plan. An Eligible Employee who is enrolled in the Plan is called Member.

An Eligible Employee is a common law employee of an Employer who is a U.S. citizen or lawfully present alien and regularly scheduled to work at least 20 hours per week. An individual who performs services for an Employer through a staffing or similar agency (sometimes called a "temporary employee") is not an Eligible Employee, regardless of whether he or she is determined to be a common law employee of an Employer. Union employees are only Eligible Employees if their applicable collective bargaining agreement provides for participation in the Plan.

Coverage for the Eligible Employee's Dependents

An Eligible Employee enrolled in the Plan may enroll his or her eligible Dependents. Covered Dependents are also called Members, unless the context suggests otherwise.

Eligible Dependents Are:

- The Employee's Spouse or Domestic Partner. For the purposes of this Plan, a Spouse is defined as a person who is legally married to the enrolling Employee under the laws of the state or other jurisdiction where such marriage occurred.
- The Employee's and/or Domestic Partner's dependent children until the end of the month in which they attain age 26, legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee's children (or children of the Employee's Spouse or Domestic Partner) for whom the Employee has legal responsibility resulting from a valid court decree. A Member may cover the children of a Spouse or Domestic Partner, even if the Spouse or Domestic Partner is not covered.
- Children who are mentally or physically impaired and totally dependent on the Employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the impairment is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically. You must notify the Claims Administrator and/or the Employer if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

Existing Members

Members and Covered Dependents previously enrolled under existing group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Otherwise, coverage will be effective based on the waiting period chosen by the Employer, which will not exceed 90 days.

New Hires

Applications for enrollment must be submitted within 31 days from the date an Employee is eligible to enroll as set by the Plan Sponsor. Applications for enrollment may be obtained from the Employer. Coverage will be effective based on the waiting period chosen by the Plan Sponsor which will not exceed 90 days. If the Employee or the Employee's Dependents do not enroll when first eligible, the Employee or the Employee's Dependents will be treated as Late Enrollees unless a Special Enrollment Period or other permitted change in coverage applies. Please refer to the "Late Enrollees" provision listed below.

Late Enrollees

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

Special Enrollment Periods

If an Employee or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Employee or Dependent must request Special Enrollment within **3**1 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes About Special Enrollment:

- Individuals enrolled during special enrollment periods are **not** Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and CHIP Special Enrollment/Special Enrollees

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

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

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

When Coverage Begins

If the Employee applies for coverage when first eligible, coverage will be effective on the date the Plan Sponsor's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Plan Sponsor requires, which will not exceed 90 days.

Changing Coverage

There may be an annual re-enrollment period during which time Members may elect to change their options.

Types of Coverage

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

Changing Coverage (Adding a Dependent)

You may add new Dependents to Your Plan by contacting Your Plan Administrator or Human Resources contact. The Plan Administrator must notify the Claims Administrator.

Coverage is provided only for those Eligible Dependents the Employee has reported to the Plan Administrator and added to his or her coverage by completing the correct application within 31 days of a Qualified Life Event. All changes in status are limited by the terms of Your Employer's cafeteria plan, the change in status rules under Section 125 of the Internal Revenue Code, and the policies and procedures of the Plan Sponsor, each to the extent applicable.

Marriage, Domestic Partnership, and Stepchildren

An Employee may add a Spouse, Domestic Partner, and other Eligible Dependents within 31 days of the date of marriage or commencement of Domestic Partnership, as applicable, by submitting a change-of-coverage form. The Effective Date of coverage is the date of notification.

If an Employee does not apply for coverage to add a Spouse, Domestic Partner, and other Eligible Dependents within 31 days of the date of marriage or commencement of Domestic Partnership, as applicable, the Spouse, Domestic Partner, and Eligible Dependents are considered Late Enrollees. Please refer to the **"Late Enrollees"** provision in this section.

Newborn and Adopted Children

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

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age to the extent required by applicable law.

OBRA 1993 and Qualified Medical Child Support Orders

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

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

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

Family and Medical Leave

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

Changing Coverage or Removing a Dependent

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

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches age 26 (see "When Coverage Terminates");
- Domestic Partner and Covered Dependents no longer meet eligibility requirements;
- Covered Dependent child becomes totally or permanently impaired.

HOW YOUR PLAN WORKS

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

Introduction

Your Plan includes a Preferred Provider Organization (PPO Network). The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your out-of-pocket expenses will be higher when You use Out-of-Network Providers. To find a Network Provider for this Plan, please see "How to Find a Provider in the Network," later in this section.

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

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied. All Covered Services must also meet the Claims Administrator's applicable medical policy and clinical Guidelines. Other limitations and exclusions as described in this Benefit Booklet also apply.

Network Services

When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

Network Providers include Primary Care Physicians/Providers (PCPs), Specialists (Specialty Care Physicians/Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for You. Referrals are never needed to visit a Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them You are an Anthem Member,
- Have Your Member Identification Card handy. The Doctor's office may ask You for Your group or Member ID number.
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Member Identification Card with You.

For services from Network Providers:

1. You will not need to file claims. Network Providers will file claims for Covered Services for You. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by Your Network Provider(s) for any Non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.
2. Precertification will be done by the Network Provider. (See the **Health Care Management – Precertification** section for further details.)

Please read the **Claims Payment** section for additional information on Authorized Services.

After Hours Care

If You need care after normal business hours, Your doctor may have several options for You. You should call Your doctor's office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When You do not use a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

For services from an Out-of-Network Provider:

- the Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see **Health Care Management – Precertification** for more details.)

Use the Mobile App to Connect with Us

As soon as You enroll in this Plan, You should download the mobile app. You can find details on how to do this at www.anthem.com**.** The goal is to make it easy for You to find answers to Your questions. You can chat with a representative live in the app, or contact us at www.anthem.com.

How to Find a Provider in the Network

There are three ways You can find out if a Provider or facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and facilities that participate in this Plan's Network.
- Search for a Provider in our mobile app.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network, based on specialty and geographic area.
- Check with Your Doctor or Provider.

If You need details about a Provider's license or training, or help choosing a Doctor who is right for You, call the Member Services number on the back of Your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

Continuation of Care

If Your Network Provider leaves our Network for any reason other than termination for cause, and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still get Network benefits. "Active treatment" includes:

- An ongoing course of treatment for a life-threatening condition.
- An ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy, and post-operative visits).
- An ongoing course of treatment for pregnancy and through the postpartum period.
- An ongoing course of treatment for a health condition for which the Physician or healthcare Provider attests that discontinuing care by the current Physician or Provider would worsen Your condition or interfere with anticipated outcomes.

An "ongoing course of treatment" includes treatments for mental health and substance use disorders.

In these cases, You may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If You wish to continue seeing the same Provider, You should contact Member Services for

details. Any decision by the Plan regarding a request for Continuation of Care/Transition of Care is subject to review.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard." This program lets You get Covered Services at the Network cost-share when You are traveling out of state and need health care, as long as You use a BlueCard Provider. All You have to do is show Your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send Your claims to the Claims Administrator.

If You are out of state and a Medical Emergency or urgent situation arises, You should get care right away.

In a non-emergency situation, You can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of Your Identification Card.

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

Please refer to **Inter-Plan Programs** in the **Claims Payment** section for more information on BlueCard.

Care Outside the United States – BlueCard Worldwide

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

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

Call the Service Center in these non-emergent situations:

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

Payment Information

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

Claim Filing

- The Hospital will file Your claim if the BlueCard Worldwide Service Center arranged Your hospitalization. You will need to pay the Hospital for the Out-of-Pocket costs You normally pay.

- You must file the claim for outpatient and Physician care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

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

Copayment
Certain Network services may be subject to a Copayment amount which is a flat-dollar amount You will be charged at the time services are rendered.

Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the **Schedule of Benefits**. Unless otherwise indicated, services which are not specifically identified in this Benefit Booklet as being subject to a Copayment are subject to the **calendar year Deductible** and payable at the **percentage payable** in the **Schedule of Benefits**.

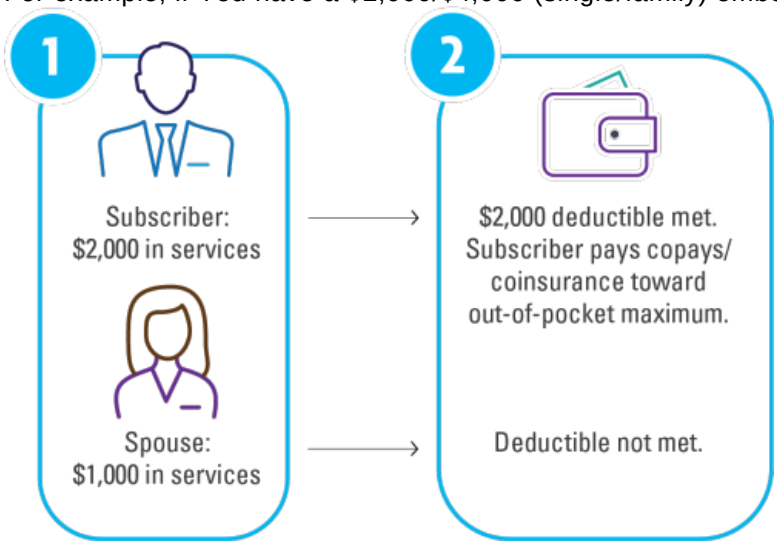
Calendar Year Deductible
Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. You must satisfy the Deductible as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits.**

Deductibles
There are two different types of Deductibles, embedded and non-embedded (True Family) Deductibles. Your Plan has an embedded Deductible.

Embedded Deductible
If You have a family Plan (two or more Members), with an embedded Deductible, meaning that there are two Deductible amounts within one Plan; single and family.

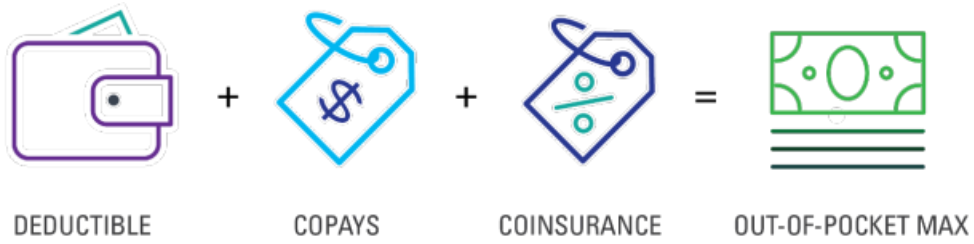
The single Deductible is embedded in the family Deductible, so **no one family member can contribute more than the single amount toward the family Deductible**. Once the Member meets their single Deductible, the Member will start paying Copays and/or Coinsurance toward the Out-of-Pocket Maximum.

For example, if You have a $2,000/$4,000 (single/family) embedded Deductible, this is how it would work:



Since the subscriber met his deductible, he was able to move on to his Copays/Coinsurance for Covered Services. The Spouse will continue to pay toward the Deductible until it is met.

Out-of-Pocket Maximum
An Out-of-Pocket Maximum is the annual limit on the amount of money that You would have to pay for healthcare services, not including monthly premiums or services not covered. After the maximum is reached, all covered health services are paid in full by the health Plan for the rest of that Plan Year.

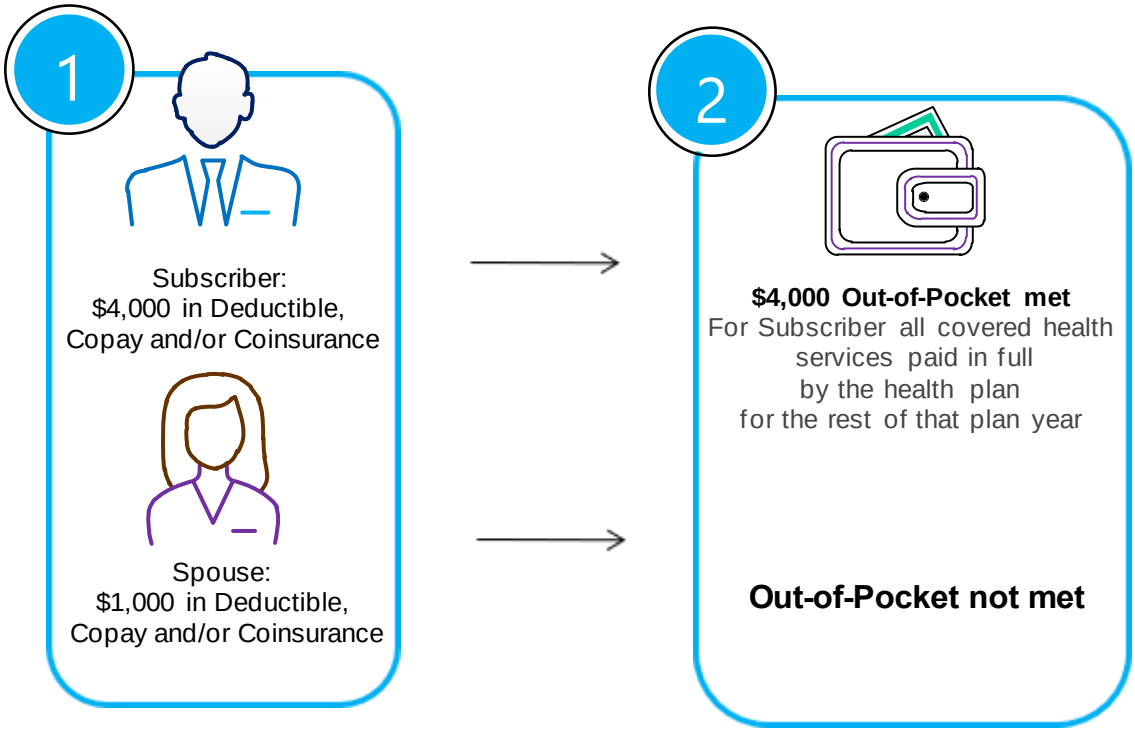


All payments that apply to the Deductible also apply to the Out-of-Pocket Maximum.

Embedded Out-of-Pocket
For family Plans (two or more members), an embedded Out-of-Pocket means that there are two Out-of-Pocket amounts within one Plan; single and family.

The single Out-of-Pocket is embedded in the family Out-of-Pocket, so **no one family member can contribute more than the single amount toward the family Out-of-Pocket**. Once the Member meets their single Out-of-Pocket, all covered health services are paid in full by the health Plan for the rest of that Plan Year.

For example, if You have a 4,000/$8,000 (single/family) embedded Out-of-Pocket, this is how it would work:



Since the subscriber met his Out-of-Pocket, he was able to move on to all covered health services paid in

full by the health Plan for the rest of that Plan Year.

The Spouse will continue to pay toward the Out-of-Pocket until it is met.

HEALTH CARE MANAGEMENT - PRECERTIFICATION

Health Care Management includes the processes of Precertification, Predetermination and Post Service Clinical Claims 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. The Plan Administrator shall have the authority to waive a requirement if, in the Plan Administrator's discretion, such exception is in the best interest of the Member or the Plan.

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

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

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

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

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

2025 Precertification List

Inpatient Admission:

- Acute Inpatient
- Acute Rehabilitation
- LTACH (Long Term Acute Care Hospital)
- Skilled Nursing Facility
- OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)
- Emergency Admissions Precertification is not required. However, Plan notification should be provided as soon as possible.

Diagnostic Testing:

- BRCA Genetic Testing
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability and Congenital Anomalies

- Gene Expression Profiling for Managing Breast Cancer Treatment
- Gene Mutation Testing for Cancer Susceptibility and Management
- Genetic Testing for Inherited Diseases
- Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP) Attenuated FAP and MYH-Associated Polyposis
- Preimplantation Genetic Diagnosis Testing
- Prostate Saturation Biopsy
- Testing for Biochemical Markers for Alzheimer's Disease
- Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders

Durable Medical Equipment (DME)/Prosthetics:

- Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output
- Compression Devices for Lymphedema
- Electric Tumor Treatment Field (TTF)
- External Upper Limb Stimulation for the Treatment of Tremors
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- High Frequency Chest Compression Devices for Airway Clearance
- Implantable Infusion Pumps
- Intrapulmonary Percussive Ventilation (IPV) Device
- Microprocessor Controlled Knee-Ankle-Foot Orthosis
- Microprocessor Controlled Lower Limb Prosthesis
- Myoelectric Upper Extremity Prosthetic Devices
- Neuromuscular Electrical Training for the Treatment of Obstructive Sleep Apnea or Snoring
- Noninvasive Electrical Bone Growth Stimulation of the Appendicular Skeleton
- Robotic Arm Assistive Devices
- Standing Frames
- Ultrasonic Diathermy Devices
- Ultrasound Bone Growth Stimulation
- Powered Wheeled Mobility Devices

Gender-Affirming Surgery

- If the benefit is covered, Precertification is required.

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related, including, but not limited to:
  - Donor Leukocyte Infusion
  - Intrathecal treatment of Spinal Muscular Atrophy (SMA) Spinraza (nusinersen)
  - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - (CAR) T-cell immunotherapy treatment, including, but not limited to:
    - Axicabtagene ciloleucel (Yescarta™)
    - Amtagvi (lifileucel)
    - Tisagenlecleucel (Kymriah™)
    - Brexucabtagene Autoleucel (Tecartus)
    - lisocabtagene maraleucel (Breyanzi)

- idecabtagene vicleucel (Abecma)
- Carvykti (ciltacabtagene autoleucel) (CAR-T)

– Gene Replacement Therapy (If the benefit is covered, Precertification is required). Including, but not limited to:
  - Gene Therapy for Ocular Conditions/ Voretigene neparvovec-rzyl (Luxturna™)
  - Gene Therapy for Spinal Muscular Atrophy/ onasemnogene abeparvovec-xioi (Zolgensma®)
  - Gene Therapy for Hemophilia
  - Gene Therapy for Beta Thalassemia Betibeglogene autotemcel (ZYNTEGLO)
  - Gene Therapy for Cerebral Adrenoleukodystrophy (CALD)
  - Gene Therapy for Duchenne Muscular Dystrophy
  - Gene Therapy for Sickle Cell Disease
  - Gene Therapy for Metachromatic Leukodystrophy

Mental Health/Substance Use Disorder (MH/SUD):

Precertification Required

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Residential Care
- Behavioral Health in-home Programs
- Applied Behavioral Analysis (ABA)*
- Intensive Outpatient Therapy (IOP)**
- Partial Hospitalization (PHP)**

*Precertification for ABA is recommended and applies unless the group specifically opts out of clinical review for this benefit. Retrospective review is allowed.

** Please check benefits for any exclusions, or specific Precertification requirements.

Other Outpatient and Surgical Services:

- Aduhelm (aducanumab)
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Allogeneic, Xenographic, Synthetic Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting
  - Insertion/injection of prosthetic material collagen implants
- Ambulance Services: Air and Water (excludes 911 initiated emergency transport)
- Axial Lumbar Interbody Fusion
- Balloon Sinus Ostial Dilation
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity (If the benefit is covered, Precertification is required.)
- Blepharoplasty, Blepharoptosis Repair, and Brow Lift
- Bone-Anchored and Bone Conduction Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, and other Breast Procedures
- Bronchial Thermoplasty
- Cardiac Contractility Modulation Therapy
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Cardioverter Defibrillator
- Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty

- Cellular Therapy Products for Allogeneic Stem Cell TransplantationCervical and Thoracic Discography
- Cochlear Implants and Auditory Brainstem Implants
- Corneal Collagen Cross-Linking
- Cosmetic and Reconstructive Services: Skin Related, including, but not limited to:
    - Brachioplasty
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Procedures Performed on the Face, Jaw, or Neck (including facial dermabrasion, scar revision)
- Cosmetic and Reconstructive Services of the Trunk and Groin, including, but not limited to:
    - Brachioplasty
    - Buttock/Thigh Lift
    - Congenital Abnormalities
    - Lipectomy/Liposuction
    - Repair of Pectus Excavatum/Carinatum
    - Procedures on the Genitalia
- Cosmetic and Reconstructive Services of the Head and Neck, including, but not limited to:
    - Facial Plastic Surgery Otoplasty - Rhinophyma
    - Rhinoplasty or Rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)
    - Rhytidectomy (Face lift)
    - Cranial Nerve Procedures
    - Ear or Body Piercing
    - Frown Lines
    - Neck Tuck (Submental Lipectomy)
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems
- Doppler-Guided Transanal Hemorrhoidal Dearterialization (THD)
- Electrophysiology-Guided Noninvasive Stereotactic Cardiac Radioablation
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- Focal Laser Ablation for the Treatment of Prostate Cancer
- Functional Endoscopic Sinus Surgery (FESS)
- Home Parenteral Nutrition
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable Infusion Pumps
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Implanted Devices for Spinal Stenosis
- Implanted Artificial Iris Devices
- Implanted Port Delivery Systems to Treat Ocular Disease
- Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain
- Implantable Shock Absorber for Treatment of Knee Osteoarthritis Intracardiac Ischemia Monitoring
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis

- Leadless Pacemaker
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia
- Mastectomy for Gynecomastia
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Meniscal Allograft Transplantation of the Knee
- Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis
- Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Panniculectomy and Abdominoplasty
- Partial Left Ventriculectomy
- Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
- Penile Prosthesis Implantation
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- Perirectal Spacers for Use During Prostate Radiotherapy
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing in the Home Setting (If the benefit is covered, Precertification is required.)
- Reduction Mammaplasty
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion, Open
- Self-Expanding Absorptive Sinus Ostial Dilation
- Sipuleucel-T (Provenge®) Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Surgical and Ablative Treatments for Chronic Headaches
- Therapeutic Apheresis
- Total Ankle Replacement
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins
- Transcatheter Heart Valve Procedures
- Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia, and Gastroparesis
- Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
- Treatment of Osteochondral Defects
- Treatment of Temporomandibular Disorders
- Treatment of Varicose Veins (Lower Extremities)
- Treatments for Urinary Incontinence
- Vagus Nerve Stimulation

- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome and Varicocele
- Venous Angioplasty with or without Stent Placement/Venous Stenting
- Viscocanalostomy and Canaloplasty
- Wireless Cardiac Resynchronization Therapy for Left Ventricular Pacing
- Wearable Cardioverter-Defibrillator

Out-of-Network Referrals:

Out-of-network services for consideration of payment at network benefit level (may be authorized, based on network availability and/or Medical Necessity.)

Radiation Therapy/ Radiology Services

- Absolute Quantitation of Myocardial Blood Flow Measurement
- Intensity Modulated Radiation Therapy (IMRT)
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Proton Beam Therapy
- Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule
- Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Lutathera, Pluvicto, Zevalin)
- Xofigo (Radium Ra 223 Dichloride)

Services not requiring pre-certification for coverage, but recommended for pre-determination of medical necessity due to the existence of post service claim edits and/or the potential cost of services to the member if denied by Anthem for lack of medical necessity:

(1) Procedures, equipment, and/or specialty infusion drugs which have medically necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines.

Failure to Obtain Precertification Penalty

IMPORTANT NOTE: IF YOU OR YOUR OUT-OF-NETWORK PROVIDER DOES NOT OBTAIN THE REQUIRED PRECERTIFICATION, the Plan does not deny Medically Necessary charges related to a Hospital admit if these services were not pre-certified. Rather a penalty is assessed. Benefits are reduced by 10% to a maximum of $1,000 per admission. Additionally, if a Member does pre-certify an admission but stays longer than the approved number days, no benefit will be payable for the expenses incurred during those additional non-approved days. This does not apply to Medically Necessary services from a network or BlueCard provider.

Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility, or attending doctor (“requesting Provider”) will get in touch with the Claims Administrator to ask for a Precertification. However, You may request a Precertification, or You may choose 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. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, GA, IN, KY, ME, MO, NH, NV, NY, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield;); and any future affiliated Blue Cross and/or Blue Shield Plans resulting from a merger or acquisition by the Claims Administrator's parent company.	Provider	• The Provider must get Precertification when required
BlueCard Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed	Member	• Member must get Precertification when required or work with your Provider to assist in obtaining Precertification. Call Member Services at the number on the back of Your Identification Card. • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **Blue Card Providers must obtain Precertification for all Inpatient Admissions.**
Out-of-Network/Non-Participating	Member	• Member must get Precertification when required or work with Your Provider to assist in obtaining Precertification. Call Member Services at the number on the back of Your Identification Card. • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary, not an emergency, or any charges in excess of the Maximum Allowed Amount
NOTE: For an Emergency Care admission, Precertification is not required. However, You, Your authorized representative, or doctor should tell the Claims Administrator as soon as You are stabilized.		

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies and procedures to assist in making Medical Necessity decisions. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically.

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 Member Services telephone number on 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/Continued Stay Review -** A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective -** A request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on Your membership card for additional information.

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

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

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

regulations. Notification may be given by the following methods:

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

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

1. You must be eligible for benefits;
2. The service or surgery must be a Covered Service under Your Plan; and
3. The service cannot be subject to an exclusion under Your Plan.
4. You must not have exceeded any applicable limits under Your Plan.

Health Plan Individual Case Management

The Claims Administrator's individual health plan case management programs (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health- related needs.

The Claims Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to You. These programs are provided by, or on behalf of and at the request of, Your health plan case management staff. These Case Management programs are separate from any Covered Services You are receiving.

If You meet program criteria and agree to take part, the Claims Administrator will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Doctor(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet Your needs. This may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator's will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if in the Claims Administrator's discretion the alternate or extended benefit is in the best interest of the Member and the Plan. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify You or Your authorized representative in writing.

BENEFITS

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

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

Ambulance Service

Medically Necessary Ambulance Services are a Covered Service when one or more of the following criteria are met:

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

- For ground ambulance, You are taken:
  - From Your home, the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, You are taken:
  - From the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and an approved Facility.
  - For air Ambulance Services, Out-of-Network Providers cannot bill You for more than Your applicable Network Deductible, Coinsurance, and/or Copayment

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency Ambulance Services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-emergency Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If You do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's Maximum Allowed Amount.

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

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

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

Other non-covered Ambulance Services include, but are not limited to, trips to:

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

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

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

Hospital to Hospital Transport
If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger Your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. **Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.**

Assistant Surgery
Services rendered by an assistant surgeon are covered based on Medical Necessity and allowable charges are limited to 20% of the primary surgeon's allowable charges.

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

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

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

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

   i. The Department of Veterans Affairs.

   ii. The Department of Defense.

   iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a Network Provider to maximize Your benefits.

Routine patient care costs include items, services, and Drugs provided to You in connection with an approved clinical trial that would otherwise be covered by this Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to our clinical coverage guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

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

Consultation Services

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

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

Dental Services

Related to Injury

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

"Initial" dental work to repair injuries due to an accident means performed within 12 months from the Injury or within 12 months of the Member's Effective Date. Treatment must be completed within 24 months of the initial treatment.

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

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

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

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

Equipment, devices, supplies, and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Emergency Services
Life-threatening Medical Emergency or serious Accidental Injury.
Coverage is provided for Hospital emergency room or freestanding emergency Facility care, including a medical or mental health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition, and within the capabilities of the staff and Facilities available at the Hospital, such further medical or mental health examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan.

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

Medically Necessary services will be covered whether You get care from a Network or Out-of-Network Provider. Emergency Care You get from an Out-of-Network Provider will be covered as a Network service and will not require Precertification. The Out-of-Network Provider can only charge You any applicable Deductible, Coinsurance, and/or Copayment and cannot bill You for the difference between the Maximum Allowed Amount and their billed charges until Your condition is stable as described in the Consolidated Appropriations Act of 2021 Notice in the **Health Benefits Coverage Under Federal Law** section. Your cost-shares will be based on the Maximum Allowed Amount

and will be applied to Your Network Deductible and Network Out-of-Pocket Limit.

Treatment You get after Your condition has stabilized is not Emergency Care. Please refer to the Consolidated Appropriations Act of 2021 Notice in the **Health Benefits Coverage Under Federal Law** section for more details on how this will impact Your benefits.

The Maximum Allowed Amount will be used to determine payment for Emergency Care from an Out-of-Network Provider. However, Member cost-share will be based on the median Plan Network contract rate paid to Network Providers for the geographic area where the service is provided.

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

Gender Affirming Surgery

This Plan provides benefits for many of the charges for gender-affirming surgery and services for Members diagnosed with Gender Dysphoria. Gender-affirming surgery and services must be approved by us for the type of procedure requested and must be authorized prior to being performed. Charges for services that are not authorized for the gender-affirming surgery and services requested will not be considered Covered Services. Some conditions apply, and all services must be authorized by us as outlined in the **Healthcare Management - Precertification** section. Please refer to the **Schedule of Benefits** section for details pertaining to Copayment and/or Coinsurance.

Services Not Eligible for Coverage
Your Plan does not include benefits for the following:
a. Services determined to be Experimental/Investigational;
b. Services provided by a non-approved Provider or at a non-approved Facility; or
c. Services not approved in advance through Precertification.

General Anesthesia Services

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

- Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:
- spinal or regional anesthesia;
- injection or inhalation of a Drug or other agent (local infiltration is excluded).

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

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See **Health Care Management - Precertification** for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is a Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which providers are approved Providers.

Services Not Eligible for Coverage
Your Plan does not include benefits for the following:

a. Services determined to be Experimental/Investigational;
b. Services provided by a non-approved Provider or at a non-approved Facility; or
c. Services not approved in advance through Precertification.

General Anesthesia Services

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

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

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

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

Habilitative Services

Benefits also include habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Home Health Care Services

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

Some special conditions apply:

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

Covered Services:

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

Covered Services for Home Health Care do not include:

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

- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.
- Dietician services.
- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.

Hospice Care Services

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties for one year after the Member's death.

Your Doctor and Hospice medical director must certify that You are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Benefit Booklet.

Hospital Services

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

Network

Inpatient Services

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

Service and Supplies

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

Length of Stay

- Determined by MedicalNecessity.

Out-of-Network

Hospital Benefits

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

Outpatient Hospital Services

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

Hospital Visits

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

Human Organ and Tissue Transplant Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants.

Covered Procedures

Covered procedures as approved by the Claims Administrator include:

- Any Medically Necessary human solid organ, tissue, and stem cell/bone marrow transplants and infusions; and
- Any Medically Necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Notification

To maximize Your benefits, You need to call the Claims Administrator's 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. Your evaluation and work up services must be provided by a Network Transplant Provider that we have chosen as a Center of Medical Excellence for Transplant Provider and/or a Provider designated as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are Network Transplant Providers.

Centers of Medical Excellence (CME) Transplant Providers

Blue Distinction Center Facility: Blue Distinction Facilities have met or exceeded national quality standards for care delivery.

Centers of Medical Excellence (CME): Centers of Medical Excellence Facilities have met or exceeded quality standards for care delivery.

Network Transplant Provider: Providers who have achieved designation as a Center of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to You and take care of certain administrative duties for the Transplant Network. A Provider may be a Network Transplant Provider for certain Covered Transplant Procedures or all Covered Transplant Procedures.

Out-of-Network (PAR) Transplant Provider: Providers participating in the Plan's networks but not designated as a Center of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.

Contact the Member Services telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information, including details regarding what is covered and whether any medical policies, Network requirements or Benefit Booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Solid Organ Transplant Procedure and one day before high-dose chemotherapy or preparative regimen for a Covered Bone Marrow/Stem Cell Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts the day of a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

In order to maximize Your benefits, the Claims 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 Claims 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 Member Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims Administrator's Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting. Your Provider must certify, and the Claims Administrator must agree that the covered procedure is Medically Necessary. Not getting Precertification will result in a denial of benefits.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches, and/or a collection 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 collection 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 collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

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

Licensed Speech Therapist Services

Services must be ordered and supervised by a Physician. Speech therapy is not covered when rendered for the treatment of Developmental Delay.

Maternity Care and Reproductive Health Services

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

Maternity benefits are provided for a female Employee, female Spouse of the Employee or a Dependent daughter.

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

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

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

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

Contraceptive Benefits
Benefits include oral contraceptive drugs, injectable contraceptive drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Infertility Services

Coverage is provided for infertility testing, and once a diagnosis of infertility has been established, coverage is also provided for artificial insemination and in vitro fertilization:

- Infertility Diagnostic Testing. Coverage is provided for certain diagnostic testing, to establish or confirm a diagnosis of Infertility after unsuccessful attempts to become Pregnant.
- Artificial Insemination. Coverage is provided for artificial insemination when the Covered Person has a diagnosis of Infertility or the Covered Person and his or her Spouse have unexplained Infertility, of at least one year of regular unprotected vaginal sexual intercourse. The Covered Person's oocytes must be fertilized with the sperm of her Spouse unless the reason for Infertility is related to the absence of sperm in the husband or the absence of oocytes in the wife; or the presence of inviable sperm in the husband or inviable oocytes in the wife. Coverage is provided for no more than six cycles. If Pregnancy does not occur in the first six cycles, a Covered Person may request prior approval from the Plan for an additional six cycles.
- In-vitro Fertilization. Coverage is provided for in-vitro fertilization, when a Covered Person has a diagnosis of Infertility or has unexplained Infertility for at least two years duration. The in-vitro fertilization procedure must be performed by a Board Certified Reproductive Endocrinology and Infertility Physician Specialist in order to be eligible for benefits. The in-vitro fertilization benefit is limited to four complete oocyte retrievals per Lifetime of the member or two live births from separate Pregnancies as a result of the in-vitro fertilization procedures. After a first live birth is achieved as a result of a successful invitro fertilization cycle, up to two additional complete oocyte retrievals may be covered. All viable embryos, fresh or frozen, must be used before undergoing additional oocyte retrieval.

The following is to be excluded:
Infertility and In-Vitro Fertilization Coverage. Benefits for Infertility diagnostic testing, artificial insemination and in-vitro fertilization are not available if:
(a) the Covered Person or his or her Spouse has previously had a voluntary sterilization; or
(b) the Infertility is related to natural age-related hormone reduction (i.e. postmenopausal or 45 years of age or older); or
(c) a surrogate is used; or
(d) the Covered Person has previously had three live births by any means.

No benefits are available for post-coital testing of cervical mucus, screening for anti-sperm antibodies, hamster testing, sperm penetration assay, assisted hatching, co-culture of embryos, cryopreservation of ovarian tissue or oocytes, cryopreservation of testicular tissues in prepubertal boys, or for storage or thawing of ovarian tissue, oocytes or testicular tissue.

Sterilization Services
Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Medical Care
General diagnostic care and treatment of illness or Injury. Some procedures require pre-certification.

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

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

Mental Healthcare and Substance Use Disorder Treatment
See the **Schedule of Benefits** for any applicable Deductible, Coinsurance, and Copayment information. Coverage for the diagnosis and treatment of mental health and substance use disorder on an Inpatient or outpatient basis will not be subject to Deductibles, Coinsurance, or Copayment provisions that are less favorable than the Deductible, Coinsurance, or Copayment provisions that apply to a physical illness as covered under this Benefit Booklet.
Covered Services include the following:

- **ABA Therapy** – Medically Necessary applied behavioral analysis services.
- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - observation and assessment by a psychiatrist weekly or more often; and
  - rehabilitation and therapy.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs, and (when available in Your area) In-Home Mental Health Programs that participate in the Network.
- **LiveHealth Online –** Virtual Visits, commonly referred to as Online visits, Telehealth, and Telemedicine when available in Your area (includes Telephonic visits). Covered Services include a medical visit with the doctor using the internet by a webcam, chat, or voice. Virtual Visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit Precertification, or doctor-to-doctor discussions.

Examples of Providers from whom You can receive Covered Services include:

- Psychiatrist
- Psychologist
- Licensed Clinical Social Worker (LCSW)
- Mental Health Clinical Nurse Specialist
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Any agency licensed by the state to give these services, when they have to be covered by law.

Nutritional Counseling
Covered Services include nutritional counseling related to the medical management of a disease state.

Obesity
Prescription drugs and any other services or supplies for the treatment of obesity are not covered. Surgical

treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan.

Online Visits

Please refer to Virtual Visits later in this section.

Oral Surgery

Covered Services include only the following:

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

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered.

Covered Services also include the following:

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Other Covered Services

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

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

Outpatient CT Scans and MRIs

These services are covered as regular Outpatient services.

Outpatient Surgery

Network Hospital Outpatient department or Network Freestanding Ambulatory Facility charges are covered as regular Outpatient services. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services”.

Physical Therapy, Occupational Therapy, Chiropractic Care

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

available when such services are necessitated by Developmental Delay.

Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, benefits are significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and out-of-pocket requirements. Physician Services may also include services provided in a physician's office for contraceptive devices, implants, and injectables. Consultations between Your Primary Care Physician and a Specialty Care Physician are included, when approved by Anthem.

Preventive Care

Preventive Services include screenings and other services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

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

Preventive Care services in this section shall meet requirements as determined by federal law. Many Preventive Care services are covered by this Plan with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider to the extent required by the Patient Protection and Affordable Care Act of 2010, as amended. That means the Plan pays 100% of the Maximum Allowed Amount. These services fall under the following broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
    a. Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
    b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one (1) pump per Benefit Period.
    c. Gestational diabetes screening
5. Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
    a. counseling;
    b. Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy; and
    c. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy, when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

    Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.
6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
    a. aspirin;
    b. folic acid supplement;

c. vitamin D supplement;

d. iron supplement; and

e. bowel preparations.

Please note that certain age and gender and quantity limitations apply.

Any recommendation or guideline is applicable to the Plan only to the extent it is determined to be current under federal regulations. Any new or additional recommendation or guideline, or any enhancement to a recommendation or guideline, described above will only be effective with respect to the Plan for the calendar year that begins at least twelve months after such change to the applicable recommendation or guideline.

You may call Member Services using the number on Your ID Card for additional information about these services. (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov; http://www.cdc.gov/vaccines/acip/index.html.)

Prosthetic Appliances

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

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

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

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, Injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: Coverage for reconstructive services does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Retail Health Clinic

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

Skilled Nursing Facility Care

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

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

- Semiprivate Room or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;

- use of special care rooms;
- pathology and radiology;
- physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

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

Benefits will not be provided when:

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

Surgical Care

Covered Services include surgical procedures including the usual pre-/post-operative care. Some procedures require pre-certification.

Travel and Lodging Benefits

Unless prohibited by law, the Claims Administrator will cover reasonable and necessary travel costs when You are required to travel to another state to obtain Covered Services that are not available within Your state.

Travel and Lodging Expenses may be available for some procedures. The Plan will assist the patient and family with travel and lodging arrangements when the Member lives 100 miles from a Facility. Services may be received at a Network Facility or non-Network Facility and covered at the same amounts. Expenses for travel and lodging for the recipient and a companion should be verified by the Plan and may be available as follows:

- Transportation is covered, including expenses for personal car mileage at the current Federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the surgery for an evaluation, the procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 per day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses; meals are not covered);
- Travel and lodging expenses are available only if the Member resides more than 100 miles from the Facility where services are received*;*
- If the patient is a Covered Dependent minor child, the transportation expenses of two companions will be covered; lodging expenses will be reimbursed at the $150 per-diem rate.
- For information about the transportation and lodging benefits, please contact Member Services at the number on the back of Your Identification card.

The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Treatment of Injury in a Physician's Office

All Outpatient surgical procedures related to the treatment of an Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit if services are rendered by a Network Provider; services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

Virtual Visits

When available in Your area, Your coverage will include Virtual Visits. Covered Services include a medical consultation using the internet via a webcam, chat, or voice. Please refer to "Physician Services" in the **Schedule of Benefits** section for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information. For mental health and substance use disorder Virtual Visits, please refer to "Mental Healthcare and Substance Use Disorder" in the **Schedule of Benefits** section. Non-Covered Services include, but are not limited to, communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage, or payment questions
- Request for referrals to Physicians outside of the online care panel
- Benefit Precertification

LIMITATIONS AND EXCLUSIONS

1. **Admissions for Non-Inpatient Services -** Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
2. **Administrative Charges -** Charges for any of the following:
    a. Failure to keep a scheduled visit
    b. Completion of claim forms or medical records or reports unless otherwise required by law
    c. For Physician or Hospital's stand-by services
    d. For holiday or overtime rates.
    e. 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.
    f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
3. **Allergy Services -** Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto injections.
4. **Alternative Therapies -** Hypnotherapy, services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki 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. This exclusion also applies to biofeedback, recreational, or educational sleep therapy or other forms of self-care or non- medical self-help training and any related diagnostic testing.
5. **Before Coverage Begins/After Coverage Ends -** Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends.
6. **Biomicroscopy -** Biomicroscopy, field charting or aniseikonic investigation.
7. **Certain Providers -** Service You get from Providers that are not licensed by law to provide Covered Services as defined in this Benefit Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
8. **Comfort and Convenience Items -** Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
9. **Complications -** Complications of non-covered procedures are not covered.
10. **Cosmetic Services/Beautification Procedures -** Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by the Claims Administrator is not covered. (See sections a. and b. below.)
    a. This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, Congenital Anomalies/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries that caused the impairment, or as a continuation of a staged reconstruction procedure, or Congenital Anomalies necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

b. This exclusion does not apply to Breast Reconstructive Surgery or other Reconstructive Surgery that is otherwise specified as covered in this Benefit Booklet.

Complications directly related to Cosmetic Surgery or other cosmetic services or treatment, as determined by the Claims Administrator, are not covered. This exclusion applies even if the original Cosmetic Surgery or other cosmetic services or treatment was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the Cosmetic Surgery or cosmetic services or treatment and would not have taken place in the absence of the Cosmetic Surgery or cosmetic services or treatment. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

11. **Court-Ordered Services -** Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.
12. **Crime and Incarceration -** Injuries received while committing a crime as well as 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 unless otherwise required by law or regulation. This exclusion does not apply if Your involvement in the crime was solely the result of a medical or mental condition, or where You were the victim of a crime, including domestic violence.
13. **Custodial Care and Rest Care -** Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain.
14. **Daily Room Charges -** Daily room charges while the Plan is paying for an Intensive Care Unit, cardiac care unit, or other special care unit.
15. **Dental Care -** Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
16. **Educational Services -** Educational services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Plan provides for neurological disorders and applied behavioral analysis), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning impairments, behavioral problems, and mental and intellectual impairment. Special education, including lessons in sign language to instruct a Member, whose ability to speak have been lost or impaired, to function without that ability, is not covered.
17. **Excessive Expenses -** Expenses in excess of the Plan's Maximum Allowed Amount.
18. **Employer or Association Medical/Dental Department -** 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.
19. **Experimental or Investigational Services -** Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Member's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

20. **Family Members -** Services rendered by a Provider who is a close relative or member of Your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.

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

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

23. **Government Programs -** Treatment where payment is made by any local, state, or federal government (except Medicaid or TRICARE to the extent prohibited by applicable law), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

24. **Health Spa -** Expenses incurred at a health spa or similar facility.

25. **Ineligible Hospital -** Any services rendered or supplies provided while You are confined in a Hospital that is an Ineligible Provider.

26. **Ineligible Provider -** Any services rendered or supplies provided while You are a patient or receive services from an Ineligible Provider.

27. **Infertility Services -** For artificial insemination; fertilization (such as In Vitro or GIFT) or procedures and testing related to fertilization; infertility drugs and related services following the diagnosis of Infertility.

28. **Inpatient Rehabilitation Programs -** Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Member is medically stable and does not require skilled nursing care or the constant availability of a Physician or:

    a. the treatment is for maintenance therapy; or

    b. the Member has no restorative potential; or

    c. the treatment is for Congenital Anomaly that is a learning or neurological impairment/disorder; or

    d. the treatment is for communication training, educational training or vocational training.

29. **Maintenance Care -** Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury or condition which is resolved or stable.

30. **Marital Counseling -** Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

31. **Medical Policy/Clinical Guidelines – Any item or service that does not meet the Claims Administrator's medical policy or clinical guidelines.**

32. **Medicare Benefits –** Except to the extent prohibited by law, services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payer whether or not the Member has enrolled in Medicare Part B. For services provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

33. **Never Events –** The Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care facility. The Provider will be expected to absorb such costs. This exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.
34. **Non-Approved Facility** - Services from a Provider that does not meet the definition of Facility.
35. **Non-Covered Services -** Any item, service, supply or care not specifically listed as a Covered Service in this Benefit Booklet.
36. **Not Medically Necessary Services-** Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
37. **Obesity Services -** Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or prescription drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition. Food supplements. Any services or supplies that involve weight reduction as the main method of treatment, including medical, or counseling. W eight loss programs included but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. This exclusion does not apply to morbid obesity surgery when approved by the Plan.
38. **Over the Counter Drug Equivalents -** Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over-the-counter products that the Plan must cover as a "Preventive Care" benefit under federal law with a Prescription.
39. **Prescription Drugs -** Any prescription drugs purchased at a retail or Mail Service Pharmacy.
40. **Private Rooms -** Private room, except as specified as Covered Services.
41. **Research Screenings –** For examinations related to research screenings, unless required by law.
42. **Reversal of Sterilization -** Services related to or performed in conjunction with reverse sterilization.
43. **Routine Examinations -** Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms illness or Injury except those which may be specifically listed as covered in this Benefit Booklet.
44. **Safe Surroundings -** Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
45. **Sclerotherapy -** Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with Sclerotherapy.
46. **Services Not Specified as Covered -** No benefits are available for services that are not specifically described as Covered Services in this Benefit Booklet. This exclusion applies even if Your Physician orders the service.
47. **Services Provided While You are Residing Overseas –** Charges for services and supplies received outside the United States by an Employee Member while the Employee Member is residing outside the United States and charges for services and supplies received by a Covered Dependent of the Employee Member who is residing outside the United States at the time the services or supplies are received. For purposes of this exclusion, a person is residing outside the United States if he or she is, or intends to be, living in a country outside the United States for an extended duration, as determined by the Plan Administrator.

48. **Sexual Dysfunction -** Medical/Surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction) regardless of origin or cause. 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.

49. **Shoes and Orthotics -** Shoe inserts, orthotics (except when prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).

50. **Smoking Cessation –** Smoking cessation products including gum, patches and Prescription Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.

51. **Spider Veins -** Treatment of telangiectatic dermal veins (spider veins) by any method.

52. **Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary -** Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to:

    a. Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards;

    b. Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs;

    c. The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment;

    d. Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers;

    e. Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a Member's house or place of business and adjustments made to vehicles;

    f. Air conditioners, humidifiers, dehumidifiers, or purifiers;

    g. Rental or purchase of equipment if You are in a facility which provides such equipment;

    h. Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications; and,

    i. Other items of equipment that the Claims Administrator determines do not meet the listed criteria.

    Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation. 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.

53. **Therapy Services -** Services for Outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.

54. **Transplant Services -** The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:

    a. Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;

    b. Transportation, travel or lodging expenses for non-donor family Members;

    c. Donation related services or supplies, including search, associated with organ acquisition and

procurement; or

d. Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered; any transplant not specifically listed as covered.

55. **Transportation -** Transportation provided by other than a state licensed professional ambulance service, and Ambulance Services other than in a Medical Emergency. Transportation to another area for medical care is also excluded except when Medically Necessary for You to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.

56. **Travel Costs and Mileage -** For mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer.

57. **Thermograms -** Thermograms and thermography.

58. **Vision Care -** Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated in this Benefit Booklet. Service or devices to correct vision or for advice on such service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.

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

60. **Waived Cost-Shares Out-of-Network -** For any service for which You are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

61. **Waived Fees -** Any portion of a Provider's fee or charge which is ordinarily due from a Member but which has been waived. If a Provider routinely waives (does not require the Member to pay) a Deductible or out-of-pocket amount, the Claims Administrator will calculate the actual Provider fee or charge the fee or charge by the amount waived.

62. **War/Military Duty -** Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.

63. **Worker's Compensation -** Care for any condition or Injury recognized or allowed as a compensable loss through any Worker's Compensation, occupational disease or 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.

CLAIMS PAYMENT

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

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

How to File Claims

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

Each person enrolled through the Plan receives an Identification Card. Remember, to receive maximum benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

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

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

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

Maximum Allowed Amount or Maximum Allowable Amount

General

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

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

- that meet the Plan's definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in this Benefit Booklet.

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

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

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

Provider Network Status

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

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

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

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

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

2. An amount based on 340% of the reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually; or

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

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

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

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above.

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

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

Member Cost Share

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

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

The Plan will not provide any reimbursement for Non-Covered Services. You may be responsible for the total amount billed by Your Provider for Non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of Your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Your Lifetime Maximum, benefit caps or day/visit limits.

In some instances, You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is not employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

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

Balance Billing

Network Provider are prohibited from balance billing. A Network Provider has signed an agreement with the Claims Administrator to accept an agreed upon fee, negotiated rate or Maximum Allowed Amount for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee except what is due under the Plan, e.g., Copayments, Deductibles or Coinsurance.

If You go to a Network Hospital or other Network Provider Medical Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or other Network Provider Medical Facility, You will be responsible for the Network cost share amount (Coinsurance or Copayment). This is because You did not have a choice in selecting the Provider employed by or contracted with the Hospital or other Medical Facility. However, You will still be responsible to pay the difference between the Network Maximum Allowed Amount, and the amount the Out-of-Network Provider charges.

If You choose to receive Covered Services from an Out-of-Network Provider (other than for Authorized Services), You will be responsible for the Out-of-Network cost share amount (Coinsurance or Copayment), and responsible to pay the difference between the Out-of-Network Maximum Allowed Amount and the amount the Out-of-Network Provider charges.

Inter-Plan Programs

Out-of-Area Services

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

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

BlueCard® Program

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

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

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

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

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

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate Your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that You accessed either inside or outside the geographic area Anthem serves, if this Booklet covers those healthcare services. Due to variations in Host Blue network protocols, You may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though You might not otherwise have been entitled to benefits if You had received those healthcare services inside the geographic area Anthem serves. But in no event will You be entitled to benefits for healthcare services, wherever You received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

Non-Participating Providers Outside Anthem's Service Area

Member Liability Calculation
When covered healthcare services are provided outside of the Claims Administrator's Service Area by non-participating providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the non- participating provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

Exceptions
In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Claims Administrator would make if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Claims Administrator will pay for services rendered by nonparticipating providers. In these situations, You may be liable for the difference between the amount that the non-participating provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

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 Out-of-Network care, and You may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Member Services number on Your ID Card or go to www.anthem.com for more information about such arrangements.

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. **In such event, the Plan may pay less for one or more of such Covered Services than it would if each Covered Service had been provided separately.** Reimbursement is limited to the Plan's Maximum Allowed Amount. **If services are performed by Out-of-Network Providers,** then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount **with or without a referral or regardless if allowed as a Covered Service**. Contact the Claims Administrator for more information.

Processing Your Claim

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

Timeliness of Filing-Member Submitted Claims

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

Necessary Information

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

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

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After You get Covered Services, we must receive written notice of Your claim within [12/15 months] in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within [12/15 months] or no benefits will be covered, unless otherwise required by law (e.g., Federal law allows exceptions for claims filed by the Veteran's Administration up to a maximum 6 years from the date of service.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If You fail to cooperate, You will be responsible for any charge for services.

Explanation of Benefits

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

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

Unauthorized Use of Identification Card

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

Assignment

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to You as opposed to any Provider for Covered Service. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" 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 Claims Administrator (whether to any Provider for Covered Service or You) will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA, if subject to ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Questions About Coverage or Claims

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

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- Provider name and address.

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

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

An oral explanation of Your benefits by an employee of the Claims Administrator, Plan Administrator or Employer or any written material provided to You that are intended to summarize or explain the information in this Benefit Booklet is not legally binding.

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

REVIEW OF CLAIMS AND YOUR RIGHT TO APPEAL

The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. In those cases, please contact Member Services by calling the number on the back of Your ID card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of Your complaint, You have the right to file an appeal, which is defined as follows:

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

- A pre-service claim is a claim for benefits under the Plan for which You have not received the benefit or for which You may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which You have received the service.

If Your claim is denied or if Your coverage is rescinded:
- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

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

Notice of Adverse Benefit Determination
If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:
- information sufficient to identify the claim involved
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA if You appeal and the claim denial is upheld;
- information about any standard internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and the denial code and its corresponding meaning (if applicable) and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on Medical Necessity or Experimental or Investigational treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist You; and,
- information regarding Your potential right to an External Review pursuant to federal law.

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

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

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

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

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

You must include Your Member identification number when submitting an appeal.

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

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

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

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

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

If the denial was based in whole or in part on a medical judgment, including whether the treatment is Experimental or Investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

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

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

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

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

For pre-service claims involving urgent/concurrent care, You may proceed with an expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To

proceed with an expedited External Review, You or Your authorized representative must contact the Claims Administrator at the number shown on Your identification card and provide at least the following information:

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

You must include Your Member identification number when submitting an appeal.

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

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

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor. All claims and appeals will be processed in accordance with such rule.

COORDINATION OF BENEFITS (COB)

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

Please note that several terms specific to this COB provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet (for example, Plan). For this COB provision only, "Plan" will have the meanings as specified below. Capitalized terms not defined in the COB Definitions section of this COB provision will have the same meanings as they have in the rest of this Benefits Booklet (for example, Deductible). In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

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

The Allowable expense under COB is generally the higher of the Primary Plan's and Secondary Plan's 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 (*carve-out)* Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long-term care policies; hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; Medicare supplement policies; excess insurance policies; and any medical payments provision of a no-fault automobile insurance policies or personal injury protection policies. The Plan shall always be secondary in coverage to any item listed in 2, regardless of any election made by You to the contrary.

Each contract for coverage under item 1. above is a separate Plan. If a Plan has multiple parts and COB rules apply only to one or more of the parts, the parts to which the COB rules apply is treated as a separate Plan from the parts to which the COB rules do not apply.

This Plan means the Medical Plan providing health care benefits described in the rest of this Benefit Booklet that the COB provision applies to and which may be reduced because of the benefits of other Plans. Any other 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 determines 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 the Primary Plan, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is the Secondary Plan, 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.

An **"Allowable expense"** for purposes of this COB section 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 Plan and Secondary Plan, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semiprivate 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 deductible under the Primary Plan that is a high-deductible health plan, if the Claims Administrator has been advised by You that all Plans covering You are high-deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, as amended.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always the Primary Plan unless the provisions of both Plans state that the complying Plan is the Primary Plan.
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 will not be a Primary Plan, even in the absence of a Coordination of Benefits provision. 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 a Secondary Plan 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 the Primary Plan. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - The Plan covering the Custodial parent;
     - The Plan covering the spouse of the Custodial parent;
     - The Plan covering the non-custodial parent; and then
     - The Plan covering the spouse of the non-custodial parent.

3. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

Secondary to Other Coverage
The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal Injury protection policy regardless of any election made by anyone to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

EFFECT ON THE BENEFITS OF THIS PLAN

When a Member is covered under two or more Plans which together pay more than this Plan's benefits, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is the Primary Plan. However, when this Plan is the Secondary Plan under the Order of Benefit Determination Rules, benefits payable by this Plan will be reduced by the combined benefits of all other Plans covering You or Your Dependent.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is the Secondary Plan, the combined benefits of this Plan and the other Plan will never exceed what would have been provided by this Plan if it was the Primary Plan. No benefits will be provided by this Plan when the amount paid by the other Plan is equal to or greater than the amount this Plan would have paid if it was the Primary Plan.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to

determine benefits payable under this Plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts the Claims Administrator may need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by this Plan is more than what should have paid under this COB provision, this Plan 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.

When a Covered Person Qualifies for Medicare

Determining Which Plan is the Primary Plan
To the extent permitted by law, this Plan will pay benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays benefits first and Medicare pays benefits second:

- Members with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

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

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

SUBROGATION AND REIMBURSEMENT

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

Definitions

As used in these Subrogation and Reimbursement provisions, “You” or “Your” includes anyone on whose behalf the plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former Plan participants and Plan beneficiaries. The provisions also apply to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan’s rights under these provisions shall also apply to the personal representative or administrator of Your estate, Your heirs or beneficiaries, minors, and legally impaired persons. If the Member is a minor, any amount recovered by the minor, the minor’s trustee, guardian, parent, or other representative, shall be subject to these Subrogation and Reimbursement provisions. Likewise, if the Member’s relatives, heirs, and/or assignees make any Recovery because of Injuries sustained by the Member, or because of the death of the Member, that Recovery shall be subject to this provision, regardless of how any Recovery is allocated or characterized.

As used in these Subrogation and Reimbursement provisions, “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers’ compensation insurance or fund, premises medical payments coverage, restitution, or “no-fault” or personal Injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements allocate or characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of Your rights of Recovery with respect to any claim or potential claim against any party, due to an Injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on Your behalf from any party or insurer responsible for compensating You for Your illnesses or Injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any Recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an Injury, illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Injury, illness or condition, up to and including the full amount of Your Recovery. 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. You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or Injuries.

Secondary to Other Coverage

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

Assignment

In order to secure the Plan’s rights under these Subrogation and Reimbursement provisions, You agree to assign to the Plan any benefits or claims or rights of Recovery You have under any automobile policy or other coverage, to the full extent of the Plan’s Subrogation and Reimbursement claims. This assignment allows the Plan to pursue any

claim You may have regardless of whether You choose to pursue the claim.

Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of Your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full Recovery, in first priority, against any Recovery You make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to Your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full Recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to Your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust

By accepting benefits from the Plan, You agree that if You receive any payment as a result of an Injury, illness or condition, You will serve as a constructive trustee over those funds. You and Your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of Your illness, Injury or condition upon any Recovery related to treatment for any illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds from Your Recovery including, but not limited to, You, Your representative or agent, and/or any other source possessing funds from Your Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before You receive any Recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make You whole or to compensate You in part or in whole for the losses, Injuries, or illnesses You sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. 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.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal Injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, illness or condition.

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal Injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or Recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- 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.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under 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 You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan’s lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

You acknowledge the Plan has the right to conduct an investigation regarding the Injury, illness or condition to identify potential sources of Recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge the Plan has notified You that it has the right pursuant to the Health Insurance Portability & Accountability Act (“HIPAA”), 42 U.S.C. Section 1301 *et seq*, to share Your personal health information in exercising these Subrogation and Reimbursement provisions.

The Plan is entitled to recover its attorney’s fees and costs incurred in enforcing its rights under these Subrogation and Reimbursement provisions.

Discretion

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

GENERAL INFORMATION

Entire Agreement

This Benefit Booklet (and any amendments thereto), the Hitachi America, Ltd. Group Health and Welfare Plan wrap document, the Hitachi America, LTD Health and Trust, and the Administrative Services Agreement, constitute the entire Plan.

If there is any conflict between either this Benefit Booklet or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control. If there is any conflict between any of the foregoing documents and the Hitachi America, Ltd. Health and Welfare Plan wrap document, the Plan wrap document controls.

Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through a written amendment authorized and signed (to the extent a signature is required) by an officer of the Plan Sponsor.

Circumstances Beyond the Control of the Plan

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

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. The Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of the 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 Member Services number on Your Identification Card.

Worker's Compensation

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

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Medicare Program

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

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

Anthem Insurance Company Inc. Note

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

Notice

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

Modifications or Changes in Coverage

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

Fraud

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

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent

to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

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

Conformity with Law

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

Clerical Error

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

Policies and Procedures

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

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

Value-Added Programs

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

Waive

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

Reservation of Discretionary Authority

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

The Plan Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Plan. This includes, without limitation, the power to construe the Plan, to determine all questions arising under the Plan, and to make, establish, amend the rules, regulations and procedures with regard to the interpretation of the Plan. The Plan Administrator's determination shall be final and conclusive on all parties, including, without limitation, the Claims Administrator.

Hitachi America, Ltd. reserves the right to amend, modify or terminate the Plan or any part of it, for any or no reason, whatsoever.

Governmental Health Care Programs

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

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers, and their healthcare benefit Plans. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem has adopted a Member Rights and Responsibilities statement.

This statement can be found in the front of this Benefit Booklet in the **Member Rights and Responsibilities** section or on our website. To access, go to www.anthem.com and select "Member Support." Under the Support column, select "FAQs" and Your state, then the "Laws and Rights That Protect You" category. Click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member's Identification Card.

Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental or Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including the Claims Administrator's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Payment Innovation Programs

The Claims Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Claims Administrator under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to health care. The Program payments are not made as payment for specific Covered Services provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by or to the Claims Administrator under the Program(s), and You do not

share in any payments made by Network Providers to the Claims Administrator under the Program(s).

Confidentiality and Release of Information

Applicable state and Federal law requires us to undertake efforts to safeguard Your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of Your medical information is available on our website and can be furnished to You upon request by contacting our Member Services department.

Obligations that arise under state and Federal law and policies and procedures relating to privacy that are referenced but not included in this Benefit Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

WHEN COVERAGE TERMINATES

Termination of Coverage (Individual)

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

Coverage of an enrolled child ends at the end of the month when the child attains the age limit shown in the Eligibility section. Coverage of an impaired child over age 26 ceases if the child is found to be no longer totally or permanently impaired. Coverage of the Spouse of a Member terminates at the end of the month as of the date of divorce or death.

Should You or any Covered Dependent be receiving covered care in the Hospital at the time Your membership terminates for reasons other than the Employer's cancellation of this Plan, or failure to pay the required premiums, benefits for Hospital Inpatient care will be provided only to the extent available for that Hospital stay.

Continuation of Coverage (Federal Law-COBRA)

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

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when Your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your Spouse and Your Dependent (other than Your Domestic Partner or, in some cases, Your Domestic Partner's children) (Your "COBRA Dependents") could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each qualified beneficiary who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Members may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their COBRA Dependents. A child born to, or placed for adoption with, a covered Member during the period of continuation coverage is also eligible for election of continuation coverage.

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

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

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

Notification Requirements
In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, the Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled COBRA Dependents to meet the Plan's definition of Dependent. While the Plan Administrator may monitor some of these criteria, such as the age of Your COBRA Dependent, it is Your obligation to ensure that the Plan Administrator to identify a COBRA dependent as a qualified beneficiary does not relieve You of the obligation to inform the Plan Administrator. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, You or a COBRA Dependent must make an election within 60 days of the date Your coverage would otherwise end, or the date the Plan Administrator notifies You or Your COBRA Dependent of this right, whichever is later. You must pay the total premium appropriate for the type of benefit coverage You choose to continue. If the premium rate changes for active Members, Your monthly premium will also change. The premium You must pay cannot be more than 102% of the premium charged for Members with similar coverage, and it must be paid to the Plan Administrator within 30 days

of the date due, except that the initial premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

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

Trade Adjustment Act Eligible Individual
If You don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused You to be eligible initially for COBRA coverage under this Plan, You will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which You become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

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

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA.
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the Employer terminates all of its group welfare benefit plans.

Other coverage options besides COBRA Continuation Coverage
Instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions
Questions concerning Your group'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 During Military Leave (USERRA)

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

Under USERRA, if the Employee (or his or her COBRA Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her COBRA Dependents) may have the right to elect to continue health coverage under the Plan. To be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her COBRA

Dependents can elect to continue coverage under the Plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the premiums and the Employee is only required to pay his or her share of the premiums without the COBRA- type 2% administrative surcharge.

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

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

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

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

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

If membership in the Plan is discontinued for non-payment of premium, the Employee's coverage will be restored to the same level of benefits as those the Employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible Dependents. The Employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

In addition, to the extent the Member may, under the policies of the Member's Employer, take a leave of absence to care for a Domestic Partner or the child of a Domestic Partner, coverage will be continued for the Member as and to the extent provided in the Employer's policies.

Please contact the Employer's Human Resources Department for state specific Family and Medical Leave Act information and information on leaves to care for Domestic Partners and their children.

Continuation of Coverage for Domestic Partners and Children of Domestic Partners

COBRA coverage is not legally required to be extended to Domestic Partners or the children of Domestic Partners. However, for purposes of medical benefits, Domestic Partners and children of Domestic Partners will be eligible for continuation coverage on substantially the same terms as Spouses and other Dependent children, respectively. Please contact the Employer's Human Resources Department for more information.

For More Information

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

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact 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 U.S Department of Labor's Employee Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at *www.dol.gov/ebsa.*

DEFINITIONS

Administrative Services Agreement
The agreement then in effect between the Claims Administrator and the Plan Sponsor regarding the administration of certain elements of the health care benefits of the Plan.

Administrative Service Fees
The amount set by the Plan Sponsor that the Member is required to pay to continue coverage.

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

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

Centers of Medical Excellence (COE) Network
A network of health care facilities selected by the Claims Administrator for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

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

Centers of Excellence (COE) Network Transplant Provider
A Provider who is a member of the Centers of Excellence Network.

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

Coinsurance
Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after You meet Your Deductible. For example, if Your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, Your Coinsurance would be $20 after You meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the **Schedule of Benefits** for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments

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

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

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

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

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

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

Copayment
A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the **Schedule of Benefits** for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the Provider when services are rendered.

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

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

Covered Services
Medically Necessary health care services and supplies that are (a) defined as Covered Services in the Plan, (b) not excluded under the Plan, (c) not Experimental or Investigational and (d) provided in accordance with the Plan.

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

Custodial Care
Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible
The portion of the bill You must pay before Your medical expenses become Covered Services.

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

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

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

Diagnostic Service(s)
Any claim for services performed to diagnose an illness or Injury, which may include, but is not limited to, ultrasounds, X-rays, and MRIs. Please refer to the **Schedule of Benefits** for more details about Your benefit coverage.

Doctor
See Physician

Domestic Partner
Your same or opposite sex Domestic Partner who meets all the requirements on a Declaration of Domestic Partnership Form required by the Plan Sponsor. You and Your Domestic Partner must submit

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

Durable Medical Equipment (DME)

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

Effective Date

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

Emergency Medical Condition

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

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

Employee

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the terms of the Plan and the employment regulations of the Employer.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer to the extent permitted by the Plan Sponsor by executing a formal document that so provides in such other method as may be acceptable to the Plan Sponsor.

Essential Health Benefits

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

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

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

Experimental or Investigational

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

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

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

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

- Is 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 or Investigational, 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by the Claims Administrator. In determining whether a Service is Experimental or Investigational, the Claims Administrator will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

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

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Documents of an IRB or other similar body performing substantially the same function; or

- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Medical records; or

- The opinions of consulting Providers and other experts in the field.

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

Fees
The periodic charges which are required to be paid by You and/or the Employer to maintain benefits under the Plan.

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

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

Health Plan Document
This Benefit Booklet (and any amendments thereto), the Hitachi America, Ltd. Group Health and Welfare Plan wrap document , the Hitachi America, Ltd. Health and Welfare Trust and the Administrative Services Agreement constitute the entire Health Plan Document.

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

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

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

Hospice Care Program

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

Hospital

- A Facility licensed as a Hospital as required by law that satisfies the Claims Administrator's accreditation requirements and is approved by the Claims Administrator. The term Hospital does not include a Provider, or that part of a Provider, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care, educational care, and subacute care.

Identification Card (or ID Card)

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

In-For-Out Benefit Treatment

A Covered Service rendered by an Out-of-Network Provider, authorized in advance by the Claims Administrator to be paid at the Network level.

Ineligible Charges

Charges for health care services that are not Covered Services because the services are not Medically Necessary, pre-certification was not obtained, or otherwise. Such charges are not eligible for payment.

Ineligible Provider

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

Infertile or Infertility

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

Injury

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

Inpatient

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

Intensive Care Unit

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

Last Date of Service

The period of time in which benefits are tracked. The Member must wait until the specific interval from the last date of service to receive Covered Services as listed in the "**Schedule of Benefits**."

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

Mail Service
A prescription drug program which offers a convenient means of obtaining maintenance medications by mail if the Member takes 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 Claims Administrator and sent directly to the Member's home.

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

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

Medical Emergency (see Emergency Medical Condition)

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

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

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

- Not Experimental or Investigational;
- 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. Preventive Service are not required to be Medically Necessary.

Member
Individuals, including an Employee and his/her Dependents, who have satisfied the Plan eligibility requirements of the Plan Sponsor, applied for coverage, and been enrolled for Plan benefits.

Mental Healthcare
Includes services for mental health and substance use disorder. Mental health and substance use disorder are conditions listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance use disorder condition.

Network
Refers to a Network Provider, Network Transplant Center, or a charge for a Covered Service that is provided by one of them.

Network Provider
A Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements.

Network Transplant Provider
A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. 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 Hire
A person who is not employed by the Employer on the original Effective Date of the Plan.

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

Out-of-Network
Refers to an Out-of-Network Provider, Out-of-Network Transplant Center, or a charge for a Covered Service that is provided by one of them.

Out-of-Network Provider
A Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the

time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

Out-of-Network Referrals

A Covered Service rendered by an Out-of-Network Provider, authorized in advance by the Claims Administrator to be paid at the Network level. This is also referred to as In-For-Out Benefit Treatment.

Out-of-Network Transplant Provider

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

Out-of-Pocket Maximum

The maximum amount of a Member's Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the required amount of the Member's Coinsurance payments is decreased to 0% of the Maximum Allowed Amount for Covered Services. However, Copayments and other scheduled charges may still be applicable.

Physical Therapy

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

Physician

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery. With respect to Behavioral Health Benefits, licensed psychologists (Ph.D. or Psy.D.) legally entitled to practice psychology are also considered Physicians.

Plan

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

Plan Administrator

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

Preventive Services

Routine health care that includes check-ups, patient counseling and screenings to prevent illness disease and other health-related problems. Covered preventive care services are those required by the Patient Protection and Affordable Care Act.

Plan Year

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

Plan Sponsor

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

Primary Care Physician (PCP)

A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other 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/Precertification/Preauthorization

A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require Prior Authorization/Precertification/Preauthorization for you to receive benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigational as those terms are defined in this Booklet.

Provider

A professional or Facility licensed when required by law that provides healthcare services within the scope of an applicable license, satisfies the Claims Administrator's accreditation requirements, and for Network Providers, is approved by the Claims Administrator. Details on the Plan's accreditation requirements can be found at https://www.anthem.com/provider/credentialing/. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question about a Provider not described in this Benefit Booklet, please call the number on the back of Your Identification Card.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order

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

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

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

Retail Health Clinic

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

Semiprivate Room

A Hospital room which contains two or more beds.

Skilled Convalescent Care

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

Skilled Nursing Facility

A Facility licensed as a Skilled Nursing Facility in the state in which it is located that satisfies the Claims Administrator's accreditation requirements and, for Network Facilities, is approved by the Claims Administrator.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care, or domiciliary care, or a place for rest, educational, or similar services.

Specialist (Specialty Care Physician/Provider or SCP)

A Specialist is a Provider who focuses on a specific area of medicine or group of patients to diagnose,

manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Spouse
For the purpose of this Plan, a Spouse is defined as a person who is legally married to the enrolling Employee under the laws of the state or other jurisdiction where such marriage occurred.

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

Telehealth
Consultations with your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet)

Telephonic
Consultations with your physician (PCP/Specialist) using audio only (telephone)

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

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

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

Virtual Visits
Virtual Visits are also known as Online Visits, Telehealth, and Telemedicine. These visits are a method of consulting with Your Physician (PCP/Specialist) using visual and/or audio devices (Computer, Smart Phone, Tablet).

You and Your
Refer to the Member and each Covered Dependent, to the extent applicable.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

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

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

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

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

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

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

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

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

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

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

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate lifetime limits, annual dollar limits, and treatment limitations (day or visit limits) on mental health and substance abuse benefits with dollar limits or day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set annual dollar limits, lifetime dollar limits, or day/visit limits on mental health or substance abuse benefits that are lower than the dollar limits or day/visit limits for certain medical and surgical benefits. A plan that does not impose annual dollar limits, lifetime dollar limits, or day/visit limits on medical and surgical benefits may not impose such dollar limits or day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose deductibles, copayment/coinsurance and out-of-pocket expenses on mental health and substance abuse benefits that are more restrictive than deductibles, copayment/coinsurance and out-of-pocket expenses applicable to other medical and surgical benefits. The Plan will comply with the Act to the extent required. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If You are declining enrollment for Yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll Yourself or Your Dependents in this Plan, if You or Your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards Your or Your Dependents' other coverage). However, You must request enrollment within 31 days after Your or Your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

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

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

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

To request special enrollment or obtain more information, call the Member Services telephone number on Your Identification Card, or contact Your Plan Administrator.

Consolidated Appropriations Act of 2021

The Consolidated Appropriations Act of 2021 (CAA) is a Federal law that includes the No Surprises Act as well as the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at a Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under Your Plan:

- Without the need for Precertification;

- Whether the Provider is Network or Out-of-Network;

If the Emergency Services You receive are provided by an Out-of-Network Provider, Covered Services will be processed at the Network benefit level.

Note that if You receive Emergency Services from an Out-of-Network Provider, Your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by a Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to Your claim if the treating Out-of-Network Provider determines You are stable, meaning You have been provided necessary Emergency Care such that Your condition will not materially worsen and the Out-of-Network Provider determines: (i) that You are able to travel to a Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) You are in condition to receive the information and provide informed consent. If You continue to receive services from the Out-of-Network Provider after You are stabilized, You will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge You any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges.**]** This notice and consent exception do not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at a Network Facility

When You receive Covered Services from an Out-of-Network Provider at a Network Facility, Your claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives You proper notice of its charges, and You give written consent to such charges. This means You will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge You any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed chargesThis requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and consent process to You if Anthem does not have a Network Provider in Your area who can perform the services You require.

Post-stabilization

Post-stabilization consists of a four-part test:

1. The attending Physician determines that the Member is able to travel using nonmedical transportation to a Network Provider or Facility within a reasonable distance, taking into consideration the Member's medical condition;
2. The Network Provider/Facility satisfies notice and consent criteria;
3. The Member or their authorized representative must be in the condition to provide informed and voluntary consent; and
4. The Network Provider/Facility must satisfy any additional state law requirements.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1. By obtaining Your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if You make an appointment within 72 hours of the services being delivered.

How Cost-Shares Are Calculated

The Maximum Allowed Amount will be used to determine payment for Emergency Care from an Out-of-Network Provider. However, Member cost-share will be based on the median Plan Network contract rate paid to Network Providers for the geographic area where the service is provided.

Appeals

If You receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at a Network Facility and believe those services are covered by the No Surprises Act, You have the right to appeal that claim. If Your appeal of a Surprise Billing Claim is denied, then You have a right to appeal the adverse decision to an Independent Review Organization as set out in the **Your Right To Appeal** section of this Benefit Book.

Provider Directories

Anthem is required to confirm the list of Network Providers in its Provider directory every 90 days. If You can show that You received inaccurate information from Anthem that a Provider was listed as in Network on a particular claim, then You will only be liable for Network cost-shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim.

Transparency Requirements

Anthem provides at its website, anthem.com, protections with respect to Surprise Billing Claims by Providers, including information on how to contact state and Federal agencies if You believe a Provider has violated the No Surprises Act. You can find this information directly at https://www.anthem.com/no-surprise-billing/

You may also obtain the following information on Anthem's website or by calling Member Services at the phone number on the back of Your Identification Card:

- Cost-sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all Network Providers

In addition, Anthem will provide access through its website to the following information:

- Network negotiated rates; and
- Historical Out-of-Network rates.

LIMITED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Employer:

(a) will not use or further disclose protected health information, except as permitted or required by the Health Plan Document and the Plan's HIPAA Policies and Procedures, as amended, or as required by law;

(b) will not use or disclose protected health information for any employment-related action or decision, or in connection with any other of the Employer's employee welfare benefit plans and will restrict access to and use of such information to those employees of the Employer and other person specified in the HIPAA Policies and Procedures;

(c) will ensure that any business associate to whom the Employer provides protected health information agrees to the restrictions and conditions of the Plan document and HIPAA Policies and Procedures, as amended, with respect to protected health information;

(d) will report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures allowed by the Plan document and HIPAA Policies and Procedures, as amended;

(e) will make protected health information available to each covered person who is the subject of the information in accordance with HIPAA;

(f) will make protected health information available for amendment and, on notice from the Plan, amend a covered person's protected health information in accordance with HIPAA;

(g) will track disclosures of protected health information that are not excepted from disclosure accounting as described by the Employer's HIPAA Policies and Procedures so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with HIPAA;

(h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA;

(i) if feasible, consistent with applicable record retention requirements, will destroy all protected health information that the Employer created or received for or from the Plan when the Employer no longer needs protected health information for the Plan Administration functions for which disclosure was made;

(j) ensure that adequate separation between the Plan and the Employer is established as follows:

(1) Such employees, or classes of employees, or other persons under the control of the Employer, as discussed in the Plan's HIPAA Policies and Procedures, shall be given access to the protected health information to be disclosed.

(2) The access to and use of protected health information by the individuals described in Subsection (1) above shall be restricted to the Plan Administration functions that the Employer performs for the Plan.

(3) In the event any of the individuals described in Subsection (1) above do not comply with the provisions of the Plan documents relating to use and disclosure of protected health information, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. Such sanctions shall be imposed in accordance with the Employer's current policy violation sanctions.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan, or to solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans;

(k) the Plan shall disclose protected health information to the Employer only upon receipt of a certification by the Employer that: (1) the Plan documents have been amended to incorporate the above provisions, and (2) the Employer agrees to comply with such provisions;

(l) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

(m) ensure that the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures;

(n) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the electronic information; and

(o) report to the Plan any Security Incident of which it becomes aware. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Notwithstanding the foregoing, HIPAA contemplates that the Plan may disclose protected health information to health care providers and business associates of the Plan in the course of treatment, payment and other health care operations of the Plan. Protected health information also may be disclosed in more limited circumstances as permitted by HIPAA and rules and regulations issued by those federal agencies responsible for the administration and enforcement of HIPAA.

The employees of the Employer and other persons who may have access to protected health information, the restrictions on their access, and the mechanism to resolve any issues of noncompliance, will be embodied in the Plan's HIPAA Policies and Procedures.

The information the Employer will return or destroy includes all protected health information in whatever form or medium (including any electronic medium), and all copies of and any data or compilations derived from such information that allow identification of any covered person who is a subject of the information. If it is not feasible to destroy all protected health information, the Employer will limit the use or disclosure of any covered person's protected health information it cannot feasibly destroy to those purposes that make the destruction of the information infeasible.

Any issues of noncompliance with HIPAA should be addressed to the Privacy Officer, c/o Hitachi America, Ltd. Group Health and Welfare Plan, 707 Westchester Avenue, Suite LL07, White Plains, NY10604-3102.

PLAN ADMINISTRATION

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

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

- **Plan Name: Hitachi America, Ltd. Group Health and Welfare Plan**

- **Plan Sponsor: Hitachi America, Ltd.**
  707 Westchester Avenue, Suite LL07
  White Plains, NY 10604-3102

- **Plan Number: 501**

- **Employer I.D. Number: 23-7688845**

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

- **Plan Year Ends:** The Plan's records are maintained on a Plan Year basis beginning each year on January 1 and ending on the following December 31.

- **Type of Administration/Funding:** Medical benefits are furnished under a health care plan funded by the Plan Sponsor on a self-funded basis with claims being administered by Anthem on behalf of the Hitachi America, Ltd. Group Health and Welfare Plan.

- **Plan Administrator and Named Fiduciary:**
  Hitachi America, Ltd.
  Attn: Director of Corporate Benefits
  800 Westchester Avenue Suite N707
  Rye Brook, NY 10573
  (914) 333-2978

- **Agent for Service of Legal Process:**
  General Counsel
  Hitachi America Ltd.
  800 Westechester Avenue, Suite N707
  Rye Brook, NY 10573

  Legal process may also be served on the Plan Administrator or the Plan's trustee.

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

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

- **Claims Procedures.**
  The Benefit Booklet contains information on reporting claims; including the time limitations on submitting a claim (see "Review of Claims and Your Right to Appeal"). Claim forms may be obtained from the Claims Administrator or the Plan Administrator. Note that the Claims Administrator is neither the Plan Administrator nor the administrator for the purposes of ERISA.

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

Statement of ERISA Rights

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

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

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

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

IT’S IMPORTANT WE TREAT YOU FAIRLY

That is why we follow Federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or impairment. For people with impairments, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on Your Identification Card for help (TTY/TDD: 711). If You think we failed to offer these services or discriminated based on race, color, national origin, age, impairment, or sex, You can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be, too. Here's the English version:
You have the right to get this information and help in Your language for free. Call the Member Services number on Your Identification Card for help. (TTY/TDD: 711)
Separate from our language assistance program, we make documents available in alternate formats for Members with visual impairments. If You need a copy of this document in an alternate format, please call the Member Services telephone number on the back of Your Identification Card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèɔ ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ɖá méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̀ɔ̃ kɔ̃ɛ ɓɛ́ m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။
အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။
(TTY/TDD: 711)
Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tö në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت

کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (Identification card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n’asụsụ gị n’efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee ná ahoot'i' táá ni nizaad k'ehjí nikáá á a'doowol t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áají' hodíílnih. (TTY/TDD: 711)

Nepali
तपाईले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईको अधिकार हो। सहायताको लागि तपाईको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong Identification card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די מעמבער באדינונגען נומער אויף אייער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. (TTY/TDD:711קארטל פאר הילף)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)