You’ve made a good decision in choosing Blue Access℠ Choice PPO

Washington University Human Resources
Excel Actives Plan ACQM2644

For more information, visit our web site at anthem.com
1/1/2015

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), RIT and certain affiliates administer non-HMO benefits underwritten by HALIC. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
Your Health Benefit Booklet
Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. RightCHOICE® Managed Care, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

In most of Missouri, Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC) and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
This Benefit Booklet has been prepared by the Administrator, on behalf of the Employer, to help explain your health benefits. This document replaces and supersedes any Benefit Booklet or summary that you have received previously. Please read this Benefit Booklet carefully, and refer to it whenever you require medical services.

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

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

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

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

**How to Obtain Language Assistance**

Anthem is committed to communicating with our Members about their health plan, regardless of their language. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.
Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in Our 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 Our website, www.anthem.com. For children, you may designates a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in Our 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 Our website, www.anthem.com.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, the Administrator is committed to making sure your rights are respected while providing your health benefits. That also means giving you access to the Administrator’s Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

• Speak freely and privately with your Doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it’s covered under your Plan.

• Work with your Doctors in making choices about your health care.

• Be treated with respect and dignity.

• Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
• 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 Administrator’s company and services.
  ○ The Administrator’s network of Doctors and other health care providers.
  ○ Your rights and responsibilities.
  ○ The rules of your health care plan.
  ○ The way your health plan works.

• Make a complaint or file an appeal about:
  ○ Your Plan
  ○ Any care you get
  ○ Any Covered Service or benefit ruling that your Plan makes.

• Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.

• Get all of the most up-to-date information from a Doctor or other health care professional provider about the cause of your illness, your treatment and what may result from it. If you don’t understand certain information, you can choose a person to be with you to help you understand.

**You have the responsibility to:**

• Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.

• Follow all Plan rules and policies.

• Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care plan requires it.

• Treat all Doctors, health care Providers and staff with courtesy and respect.

• Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.

• Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.

• Follow the care plan that you have agreed on with your Doctors or health care Providers.

• Give the Administrator, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.

• Let the Administrator customer service department know if you have any changes to your name, address or family members covered under your Plan.
The Administrator is committed to providing quality benefits and customer service to its Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact the Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.
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The Schedule of Benefits is a summary of the Deductibles, Coinsurance, maximums and other limits that apply when you receive Covered Services from a Provider. Please refer to the "Covered Services" section of this Benefit Booklet for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any endorsements, amendments, or riders.

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

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

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

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

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

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

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

**DEPENDENT AGE LIMIT**  
To the end of the month in which the child attains age 26.

**DEDUCTIBLE**

<table>
<thead>
<tr>
<th></th>
<th><strong>Network</strong></th>
<th><strong>Non-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Per Member</strong></td>
<td>Employer</td>
<td>$500</td>
</tr>
<tr>
<td></td>
<td>Network Provider: $500</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Other Network Providers: $500</td>
<td></td>
</tr>
<tr>
<td><strong>Per Family</strong></td>
<td>Employer</td>
<td>$1,500</td>
</tr>
<tr>
<td></td>
<td>Network Provider: $1,500</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Other Network Providers: $1,500</td>
<td></td>
</tr>
</tbody>
</table>

The Deductible applies to all Covered Services with a Coinsurance, except for the following:

- Hospital and surgical services for the treatment of morbid obesity (Network only)

The Network Deductible is combined for the Employer (Washington University) and all other Network Providers.

Charges that apply to one deductible also apply to the other.

**OUT-OF-POCKET LIMIT**

<table>
<thead>
<tr>
<th></th>
<th><strong>Network</strong></th>
<th><strong>Non-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Per Member</strong></td>
<td>Employer</td>
<td>$3,500</td>
</tr>
<tr>
<td></td>
<td>Network Provider: $2,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Other Network Providers: $2,000</td>
<td></td>
</tr>
<tr>
<td><strong>Per Family</strong></td>
<td>Employer</td>
<td>$7,000</td>
</tr>
<tr>
<td></td>
<td>Network Provider: $4,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Other Network Providers: $4,000</td>
<td></td>
</tr>
</tbody>
</table>

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

- Surgical Treatment of Morbid Obesity Services (Network only)
- Non-Network Human Organ and Tissue Transplant services
- Transgender Surgical Services
Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period, except for the services listed above.

The Network Out-of-Pocket is combined for the Employer (Washington University) and all other Network Providers.

All Coinsurance expenses apply to both the Network and Non-Network Coinsurance maximums. (Except: Coinsurance expenses for Non-Network Substance Abuse care do not apply to any Coinsurance maximums.)

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>COINSURANCE/MAXIMUM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td><strong>Ambulance Services (Emergency)</strong></td>
<td>Employer Network Provider: 20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>All Other Network Providers: 20% Coinsurance</td>
</tr>
</tbody>
</table>

Note: Emergency ambulance services will always be covered at the Network level.

| **Ambulance Services (non-emergency)** | Employer Network Provider: 20% Coinsurance | 20% Coinsurance |
| All Other Network Providers: 20% Coinsurance |

Note: Non-emergency ambulance services will always be covered at the Network level.

| **Autism Services** | 20% Coinsurance | 40% Coinsurance |

Coverage for the diagnosis and treatment of autism spectrum disorders will not be subject to any greater Deductible or Coinsurance than is applicable to other physical health care services covered by this Plan. Any dollar or visit limits listed elsewhere in this Benefit Booklet will not apply to services rendered in the diagnosis or treatment of Autism Spectrum Disorders. Age limits, other than the age limit for Dependent eligibility, also will not apply to services rendered in the diagnosis or treatment of Autism Spectrum Disorders.

**Behavioral Health Services**

**Mental Health & Substance Abuse Services (Note: All reference to Employer Network are Washington University Network).**

Coverage for the treatment of Behavioral Health and Substance Abuse conditions is provided in compliance with federal law.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Employer Network Provider</th>
<th>All Other Network Providers</th>
<th>coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility Services</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient Facility Services (Includes Outpatient Hospital/Alternative Care Facility)</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Office Visits</td>
<td>10%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Other Outpatient Services</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Dental Services (only when related to accidental injury or for certain members requiring general anesthesia)</td>
<td>20%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Diabetic Equipment, Education and Supplies</td>
<td>20%</td>
<td>40%</td>
<td></td>
</tr>
</tbody>
</table>
For information on equipment and supplies, see "Medical Supplies, Durable Medical Equipment, and Appliances".

Screenings for gestational diabetes are covered under “Preventive Care.”

For information on diabetic education services, see "Physician Home Visits and Office Services".

Note: The Plan will pay for Covered Health Services for medical education services, subject to Physician referral, that are provided in a Physician’s office by an appropriately licensed healthcare professional.

### Diagnostic Services

<table>
<thead>
<tr>
<th></th>
<th>20% Coinsurance</th>
<th>40% Coinsurance</th>
</tr>
</thead>
</table>

Note: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services are subject to 20% Coinsurance (Network) or 40% Coinsurance (Non-Network) regardless of setting where Covered Services are received.

### Emergency Room Services

<table>
<thead>
<tr>
<th></th>
<th>Employer Network Provider: 20% Coinsurance</th>
<th>Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Plan’s Maximum Allowable Amount.</th>
</tr>
</thead>
</table>

All Other Network Providers: 20% Coinsurance

### Home Care Services

<table>
<thead>
<tr>
<th></th>
<th>Employer Network Provider: 20% Coinsurance</th>
<th>40% Coinsurance</th>
</tr>
</thead>
</table>

All Other Network Providers: 20% Coinsurance

### Benefit Period Maximum Visits

100 visits, combined Network and Non-Network

Note: Maximum does not include Home Infusion Therapy, post-delivery Home Care visits, or Private Duty Nursing rendered in the home.
**Hospice Services**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Employer Network Provider</th>
<th>20% Coinsurance</th>
<th>40% Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other Network Providers</td>
<td>20% Coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hospice is limited to 180 Home Health visits and 100 Inpatient days, combined Network and Non-Network.

**Inpatient and Outpatient Professional Services**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Employer Network Provider</th>
<th>20% Coinsurance</th>
<th>40% Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other Network Providers</td>
<td>20% Coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Inpatient Facility Services**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Employer Network Provider</th>
<th>20% Coinsurance</th>
<th>40% Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other Network Providers</td>
<td>20% Coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Benefit Period Maximum Inpatient days for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)

60 Inpatient days, combined Network and Non-Network.

Benefit Period Maximum days for Skilled Nursing Facility

70 days, combined Network and Non-Network.

**Mammograms (Outpatient)**

- Diagnostic mammograms
  - Employer Network Provider: No Coinsurance up to the Maximum Allowable Amount
  - All Other Network Providers: No Coinsurance up to the Maximum Allowable Amount

- Routine mammograms
  - Please see the “Preventive Care Services” provision in this Schedule.

**Maternity Services**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>20% Coinsurance</th>
<th>40% Coinsurance</th>
</tr>
</thead>
</table>

Health Benefit Booklet
### Medical Supplies, Durable Medical Equipment and Appliances

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Employer Network Provider</th>
<th>All Other Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Network</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>All Other Network</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
</tbody>
</table>

Note: If durable medical equipment or appliances are obtained through your PCP/SCP or another Network Physician’s office, Urgent Care Center Services, Other Outpatient Services or Home Care Services, the Coinsurance listed above will apply in addition to the Coinsurance in the setting where Covered Services are received.

### Outpatient Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Employer Network Provider</th>
<th>All Other Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery Hospital/Alternative Care Facility</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Outpatient Surgery Hospital/Alternative Care Professional Services</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Other Outpatient Services (including chemotherapy, dialysis and cardiac rehabilitation)</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
</tbody>
</table>

### Physician Home Visits and Office Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Employer Network Provider</th>
<th>All Other Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Specialty Care Physician (SCP)</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Service</td>
<td>Employer Network Provider: 10% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Online Visits</td>
<td>All Other Network Providers: 20% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>All Other Network Providers: 20% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Note: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received in a Physician’s office are subject to the Other Outpatient Services Coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>No Coinsurance up to the Plan’s Maximum Allowable Amount</td>
<td></td>
</tr>
<tr>
<td>Surgical Services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>Cochlear implants are covered once per every 5 years with a $40,000 maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Treatment of Morbid Obesity and Hospital charges (not subject to the deductible)</td>
<td>Employer Network Provider: 10% Coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Other Related Morbid Obesity Services</td>
<td>Employer Network Provider: 10% Coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Service</td>
<td>Employer Network Provider</td>
<td>10% Coinsurance</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder Services</td>
<td>All Other Network Providers</td>
<td>10% Coinsurance</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>Employer Network Provider</td>
<td>10% Coinsurance</td>
</tr>
</tbody>
</table>

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

Benefit Period Maximum Visits for:

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational, Speech Therapy and Chiropractic Services</td>
<td>150 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.</td>
</tr>
<tr>
<td>Transgender Surgical Services (Gender Dysphoria Services)</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>$75,000</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services</td>
<td>20% Coinsurance</td>
</tr>
</tbody>
</table>
The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

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

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

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 Administrator to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)

<table>
<thead>
<tr>
<th>Transplant Benefit Period</th>
<th>Network Transplant Provider</th>
<th>Non-Network Transplant Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Transplant Case Manager for specific Network Transplant Provider information) for services received at or coordinated by a Network Transplant Provider Facility.</td>
<td>Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Network Transplant Provider</th>
<th>Transplant Provider</th>
<th>Non-Network Transplant Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Applicable</td>
</tr>
</tbody>
</table>

During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.
<table>
<thead>
<tr>
<th>Covered Transplant Procedure during the Transplant Benefit Period</th>
<th>Network Transplant Provider Facility</th>
<th>Non-Network Transplant Provider Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>During the Transplant Benefit Period, No Coinsurance up to the Plan’s Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid at 20% Coinsurance.</td>
<td>During the Transplant Benefit Period, You will pay 40% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the Provider is also a Network Provider for the Plan (for services other than Covered Transplant Procedures), then you will <strong>not</strong> be responsible for Covered Services that exceed the Plan’s Maximum Allowable Amount.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the Provider is a Non-Network Provider for the Plan, you <strong>will</strong> be responsible for Covered Services that exceed the Plan’s Maximum Allowable Amount.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prior to and after the Transplant Benefit Period, Covered Services will be paid at 40%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Transplant Procedure during the Transplant Benefit Period</th>
<th>Network Transplant Provider Professional and Ancillary (non-Hospital) Providers</th>
<th>Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure</td>
<td>No Coinsurance up to the Plan’s Maximum Allowable Amount</td>
<td>You are responsible for 40% of the Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.</td>
</tr>
<tr>
<td>Covered, as approved by the Plan, up to a $30,000 benefit limit per transplant</td>
<td>Covered, as approved by the Plan, up to a $30,000 benefit limit. You will be responsible for 40% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.</td>
<td></td>
</tr>
</tbody>
</table>
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)  

No Coinsurance up to the Plan’s Maximum Allowable Amount  
You are responsible for 40% of the Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.

5 COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. To receive maximum benefits for Covered Services, care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, except for Emergency Care and ambulance services. Services that are not received from a PCP, SCP or another Network Provider or approved as an Authorized Service will be considered a Non-Network service, except as specified above. To receive maximum benefits at the lowest Out-of-Pocket expense, Covered Services must be provided by an Employer Network Provider. Covered Services received from any other Network Provider are also covered at the Network level but require a higher Coinsurance than an Employer Network Provider. Services that are not received from a PCP, SCP, Employer Network Provider, or another Network Provider or approved as an Authorized Service will be considered a Non-Network service, except as specified above.

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

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

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

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

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

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

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

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

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

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

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

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

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

Ambulance services or emergency medical response agencies that are licensed by the state of Missouri to provide the above Covered Services will be paid directly by the Plan.

Autism Services

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

Benefits are available for the treatment of Autism Spectrum Disorders. The following definitions apply to this section only:
**Autism Service Provider** means any person, entity, or group that provides diagnostic or treatment services for Autism Spectrum Disorders who is licensed or certified by the state of Missouri, or any person who is licensed under chapter 337 as a Board Certified Behavior Analyst by the Behavior Analyst Certification Board or licensed under chapter 337 as an Assistant Board Certified Behavior Analyst.

**Autism Spectrum Disorders** means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

**Line Therapist** means an individual who provides supervision of an individual with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed Behavior Analyst;

**Benefits for the Diagnosis and Treatment of Autism Spectrum Disorders**

Benefits include Medically Necessary Covered Services to diagnose and treat Autism Spectrum Disorders when prescribed or ordered for a Member diagnosed with an Autism Spectrum Disorder by a licensed Physician or licensed Psychologist.

Covered Services include the following:

- Diagnosis of Autism Spectrum Disorders – Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an Autism Spectrum Disorder;

- Habilitative or rehabilitative care – Professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis from a licensed Autism Service Provider or Line Therapist under the direct supervision of a licensed Behavioral Analyst, which are necessary to develop the functioning of the Member;

- Psychiatric care – Direct or consultative services provided by a licensed Psychiatrist;

- Psychological care – Direct or consultative services provided by a licensed Psychologist;

- Therapeutic care – Services provided by licensed Speech Therapists, Occupational Therapists, or Physical Therapists;

- Equipment – Medically Necessary equipment for the treatment of Autism Spectrum Disorders;

The Plan may require your Provider to submit a treatment plan in order to determine when benefits for Applied Behavior Analysis (ABA) should be available. The Plan will not require this more than once every six months for outpatient ABA services, unless your Physician or Psychologist agrees to provide a treatment plan more frequently.

**Behavioral Health Services**

**Mental Health and Substance Abuse Services**

See the Schedule of Benefits for any applicable Deductible and Coinsurance information. Coverage for Inpatient Services, Outpatient Services, and Physician Home Visits & Office Services for the treatment of Behavioral Health conditions is provided in compliance with federal law.
Behavioral Health Services coverage includes Residential Treatment services. Residential Treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

**Dental Services**

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

**Related to Accidental Injury**

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

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

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

Benefits are provided only for the administration of general anesthesia and for both facility and professional charges occurring in connection with dental services provided for the following Members:

1. A Member through the age of four;
2. A Member who is severely disabled; and
3. A Member who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental services are provided.

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.
Diabetic Equipment, Education and Supplies

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

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

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

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

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Preventive Care Services” except those covered by the prescription drug plan.

Diagnostic Services

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

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

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

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

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

Emergency Care and Urgent Care Services

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

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance or Deductible. The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be:

1. The amount negotiated with Network Providers for the emergency service furnished;
2. The amount for the emergency service calculated using the same method We generally use to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
3. The amount that would be paid under Medicare for the emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

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

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

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

**Urgent Care Center Services**

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. However, you must obtain Urgent Care services from a Network Provider to receive maximum benefits. Urgent Care Services received from a Non-Network Provider will be covered as a Non-Network service and you will be responsible for the difference between the Non-Network Provider’s charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance or Deductible.

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

See your Schedule of Benefits for benefit limitations.
Gender Dysphoria Services

WUSTL Health plans will pay for Covered Health Services for the treatment of gender dysphoria, as follows:

- Hormone replacement therapy services appropriate to the Individual’s gender identity, i.e. hormones of the desired gender;
- Inpatient or outpatient mental health services connected with gender dysphoria;
- Physician office services and diagnostic services to monitor the safety and efficacy of continuous hormone therapy;
- Gender reassignment surgical services, as medically appropriate, including genital surgery and surgery to change specified secondary sex characteristics, specifically:
  - Thyroid chondroplasty (removal of the Adam’s Apple);
  - Bilateral Mastectomy;
  - Augmentation mammoplasty if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role; and
  - Other procedures consistent with accepted medical practice for the treatment of gender dysphoria according to the World Professional Association for Transgender Health Clarification Statement and Standards of Care.

The health plan will pay for covered gender reassignment surgical services, subject to plan deductibles and co-insurance, as outlined below. Coverage for gender reassignment surgery benefits will be limited to a lifetime maximum benefit of $75,000. The required co-insurance for gender reassignment surgery benefits will not apply to the annual out-of-pocket maximum.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO Plans</td>
<td>20%, after deductible</td>
<td>40%, after deductible</td>
</tr>
</tbody>
</table>

Covered non-surgical gender dysphoria services will be paid the same as any other covered services under the plans.

Coverage for gender reassignment surgical services is subject to prior authorization by the applicable health insurance carrier. The patient must meet all of the following eligibility criteria for genital surgery and surgery to change secondary sex characteristics:

- Must be age 18 or older;
- Must have completed 12 months of continuous hormone therapy for those without contraindications;
- Must have completed 12 months of successful continuous fulltime real life experience in the desired gender; and
- Must have medical documentation showing that the patient has been properly assessed according to recognized medical practice, World Professional Association for Transgender Health Clarification Statement and Standards of Care.
The following services relating to gender dysphoria are not covered:

- Treatment received outside the United States
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Sperm preservation in advance of hormone treatment or gender surgery
- Cryopreservation of fertilized embryos
- Voice modification surgery or voice therapy
- Facial feminization surgery, including but not limited to facial bone reduction, face "lift", facial hair removal, and certain facial plastic reconstruction
- Suction-assisted lipoplasty of the waist
- Rhinoplasty, blepharoplasty or abdominoplasty, unless criteria for those services are met
- Surgical or hormone treatment for participants under age 18
- Surgical treatment not prior-authorized by the insurance carrier
- Pubertal suppression therapy
- Services that exceed the maximum dollar limit under the plan

**Definition:**

Gender Dysphoria is a condition characterized by all of the following diagnostic criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his/her body as congruent as possible with the preferred sex through surgery and hormone treatment;
2. The transsexual identity has been present persistently for at least two years;
3. The condition is not a symptom of a mental disorder; and
4. The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Home Care Services**

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

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

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional Guidance.
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by the Administrator, on behalf of the Employer, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.

- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.

- Medical/Surgical Supplies.

- Durable Medical Equipment.

- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.

- Home or Outpatient hemodialysis services (these are covered under Therapy Services).

- Physician charges.

- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)

- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.

- Services provided by a member of the patient's immediate family.

- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

- Private duty nursing

**Home infusion therapy** will be paid only if you obtain prior approval from the Administrator's Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

**Hospice Services**

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

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

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

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

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

**Inpatient Services**

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

Inpatient Services include:

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

**Room, Board, and General Nursing Services**

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

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Services.
- Therapy Services.

Professional Services

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

Maternity Services

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

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

An elective (voluntary) abortion is one performed for reasons other than described above. Regardless of Medical Necessity, the Plan does not pay Covered Services from a Provider for elective abortion accomplished by any means.

Maternity services for a Dependent daughter are covered.

If the Member is in the first trimester of her pregnancy on her Effective Date, she must use a Network Provider to have Covered Services paid at the Network level. However, if the Member is in the second or third trimester of her pregnancy (13 weeks or later) on her Effective Date, and her Physician is
not a Network Provider, she will not be required to change to a Network Provider for the remainder of her pregnancy. If the Member completes a Continuation of Care Request Form and submits it to the Administrator, Covered Services (including obstetrical care provided by that Provider through the end of the pregnancy and for the immediate post-partum period) will be paid at the Network level.

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

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

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

In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

1. the antepartum, intrapartum, and postpartum course of the mother and infant;
2. the gestational stage, birth weight, and clinical condition of the infant;
3. the demonstrated ability of the mother to care for the infant after discharge; and
4. the availability of post-discharge follow-up to verify the condition of the infant after discharge.

**Covered Services include two at-home post delivery care visits** at your residence by a Physician or Nurse performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

1. physical assessment of the newborn and mother;
2. parent education;
3. assistance and training in breast or bottle feeding;
4. education and services for complete childhood immunizations; and
5. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

These visits will not be subject to any Home Health Care maximums.

**Medical Supplies, Durable Medical Equipment, and Appliances**

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

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

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

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

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

The Plan may establish reasonable quantity limits for certain supplies, equipment or appliances described below.

Covered Services may include, but are not limited to:

- Medical and surgical supplies – Covered Services include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

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

- Covered Services include the following:
  PKU formula and low protein modified food products for the treatment of phenylketonuria or any inherited diseases of amino acids and organic acids (covered only for children through age 5.) Low protein modified food products are foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein foods do not include foods that are naturally low in protein.

Non-Covered Services include but are not limited to:

1. Adhesive tape, bandages, cotton tipped applicators
2. Arch supports
3. Doughnut cushions
4. Hot packs, ice bags
5. Vitamins
6. Medijectors
7. Diabetic supplies

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

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

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Insulin pump and supplies
7. Tracheotomy tube
8. Cardiac, neonatal and sleep apnea monitors

9. Augmentive communication devices are covered when the Administrator approves based on the Member’s condition.

**Non-covered** items may include but are not limited to:

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

If you have any questions regarding whether a specific durable medical equipment is covered, call the customer service number on the back of your Identification Card.

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

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

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

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women’s Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply. No time limits will be imposed for the receipt of the breast prosthesis.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the
time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).
10. Hearing Aids provided to a newborn for initial amplification following a newborn hearing screening (including any necessary rescreening, audiological assessment and follow-up; see “Preventive Care”). A hearing aid is an electronic device worn or implanted for the purpose of amplifying sound and assisting the physiological process of hearing.

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered, call the customer service number on the back of your Identification Card.

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

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

2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts. Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member’s situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired. Non-Covered Services include but are not limited to:

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

If you have any questions regarding whether a specific orthotic is covered, call the customer service number on the back of your Identification Card.

Outpatient Services

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

Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by the Plan. Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to the section titled Behavioral Health Services for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

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

Physician Home Visits and Office Services

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

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

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office.

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

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

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

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

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

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

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

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of Covered Services include screenings for:
   - Breast cancer,
   - Cervical cancer,
   - Colorectal cancer,
   - High blood pressure,
   - Type 2 Diabetes Mellitus,
   - Cholesterol,
   - Child and adult obesity.

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

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

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
   - Women’s contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
   - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
   - Gestational diabetes screening.


Covered Services also include the following services required by federal law:
• Well-baby and well-child care examinations for children through the age of 12, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services include, but are not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

• Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) and as provided by the Missouri Department of Health and Senior Services for children through the age of five. These immunizations will not be subject to any Deductible, Coinsurance or benefit maximums.

• The following for newborns: hearing screenings, necessary re-screenings, audiology assessment and follow-up.

• Pelvic examinations.

• Routine cytologic screening (including pap test).

• Screening mammograms for asymptomatic women.

• Routine bone density testing for women.

• Routine prostate exam and prostate specific antigen testing.

• Routine colorectal cancer examination and related laboratory tests.

• Testing of pregnant women and other Members for lead poisoning.

• Routine patient care costs for reasonable and Medically Necessary Drugs, devices, medical treatments, procedures or other technology included as part of a Phase II, III or IV clinical trial undertaken to treat cancer. The clinical trial must be underwritten by a National Institute of Health Cooperative or an equivalent entity. Covered care includes routine patient care costs incurred for Drugs and devices related to the clinical trial. Covered items do not include: the investigational item or service itself; items and services used only for data collection, not for clinical management of the patient; or items and services customarily provided by research sponsors at no charge.

Other Covered Services include:

• Routine hearing screening.

Surgical Services

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

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

• Performance of generally accepted operative and other invasive procedures;
• The correction of fractures and dislocations;
• Anesthesia surgical assistance when Medically Necessary;
• Usual and related pre-operative and post-operative care;
• Cochlear implants;
• Other procedures as approved by the Administrator, on behalf of the Employer.

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

Covered Surgical Services include, but are not limited to:

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

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 Benefit Booklet.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women’s Health & Cancer Rights Act became effective for the Plan, and who elects breast reconstruction, will also receive coverage for:

• reconstruction of the breast on which the mastectomy has been performed;
• surgery and reconstruction of the other breast to produce a symmetrical appearance; and
• prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

There is no time limit for the receipt of prosthetic devices or reconstructive surgery.

Sterilization

Sterilization is a Covered Service. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

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

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

They are covered if provided within the Plan’s guidelines.

Therapy Services

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

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

Physical Medicine Therapy Services

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

- **Physical therapy** not including Chiropractic Services, including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

- **Speech therapy** for the correction of a speech impairment.

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person’s ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
• **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function. Manipulation therapy does not include chiropractic services, as identified below.

• **Chiropractic services** are available on a short-term acute basis. Chiropractic services are services provided by a licensed Chiropractor acting within the scope of his or her practice. Coverage includes the initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder, subject to the terms and conditions of the Plan. Benefits are only available for chiropractic services from a Network Provider. Care provided by any other Provider is not eligible for benefits.

**Other Therapy Services**

• **Cardiac rehabilitation** to restore an individual’s functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

• **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

• **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine.

• **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

• **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

• **Pulmonary rehabilitation** to restore an individual’s functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician’s office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

**Physical Medicine and Rehabilitation Services**

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy (not including Chiropractic Care), occupational therapy, speech therapy and services of a Social Worker or Psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.
Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

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

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

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

**Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services**

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

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

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

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

**Covered Transplant Procedure**

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

Covered Transplant Procedures include treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation.

**Transplant Benefit Period**

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

**Prior Approval and Precertification**

In order to maximize your benefits, you are strongly encouraged you to call the 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. The Administrator will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or Exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if the Administrator issues a prior approval for the Covered Transplant Procedure, it is recommended that you or your Provider call the Administrator's Transplant Department for precertification prior to the transplant, whether this is performed in an Inpatient or Outpatient setting.

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

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

**6 NON COVERED SERVICES/EXCLUSIONS**

The following section indicates certain items that are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

The Plan does not provide benefits for procedures, equipment, services, supplies or charges:

1. that the Administrator, on behalf of the Employer, determines are not Medically Necessary or does not meet the Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines, except reasonable and Medically Necessary Drugs, devices, medical treatments, procedures or other technology included as part of a Phase III or IV clinical trial undertaken to treat cancer. The clinical trial must be underwritten by a National Institute of Health Cooperative or an equivalent entity. Covered care includes routine patient care costs incurred for Drugs and devices related to the clinical trial. Covered items do not include: the investigational item or service itself; items and services used only for data collection, not for clinical management of the patient; or items and services customarily provided by research sponsors at no charge.

2. received from an individual or entity that is not licensed by law to provide Covered Services, as defined in this Benefit Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
3. that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator, on behalf of the Employer, except reasonable and Medically Necessary services or supplies included as part of a clinical trial sponsored by Washington University in St. Louis or as part of a Phase III or IV clinical trial undertaken to treat cancer. The clinical trial must be underwritten by a National Institute of Health Cooperative or an equivalent entity. Covered care includes routine patient care costs incurred for Drugs and devices related to the clinical trial. Covered items do not include: the investigational item or service itself; items and services used only for data collection, not for clinical management of the patient; or items and services customarily provided by research sponsors at no charge. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if the Administrator, on behalf of the Employer, deems it to be Experimental/Investigational.

4. for any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers’ Compensation Act or other similar law. If Workers’ 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.

5. to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

6. for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber’s request, the Administrator, on behalf of the Employer, will refund any Fees paid from the date the Member enters the military.

7. for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

8. for court ordered testing or care unless the service is Medically Necessary.

9. for which you have no legal obligation to pay in the absence of this or like coverage.

10. for the following:
   • Physician or Other Practitioners’ Charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member;
   • surcharges for furnishing and/or receiving medical records and reports.
   • charges for doing research with Providers not directly responsible for Your care.
   • charges that are not documented in Provider records.
   • charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.

11. received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

12. prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.
13. for completion of claim forms or charges for medical records or reports, unless otherwise required by law.
14. for missed or canceled appointments.
15. for mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by the Administrator, on behalf of the Employer, or specifically stated as a Covered Service.
16. in excess of the Plan’s Maximum Allowable Amounts.
17. incurred prior to your Effective Date.
18. incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
19. for reconstructive services, except as specifically stated in the “Covered Services” section of this Benefit Booklet, or as required by law.
20. provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by the Administrator, on behalf of the Employer, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under the Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.
21. for maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
22. for the following:
   - Custodial, convalescent care or rest cures; domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
   - care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
• care provided or billed by residential treatment centers or facilities. This includes, but is not limited to, individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
• services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
• wilderness camps

23. for routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
   • cleaning and soaking the feet.
   • applying skin creams in order to maintain skin tone.
   • other services that are performed when there is not a localized illness, injury or symptom involving the foot.

24. for surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

25. for dental treatment, regardless of origin or cause, except as specified elsewhere in this Benefit Booklet. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:
   • extraction, restoration and replacement of teeth.
   • medical or surgical treatments of dental conditions.
   • services to improve dental clinical outcomes.

26. for treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

27. for Dental implants.

28. for Dental braces.

29. for Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as explained in the “Covered Services” section of this Benefit Booklet. The only exceptions to this are for any of the following:
   • transplant preparation.
   • initiation of immunosuppressives.
   • direct treatment of acute traumatic injury, cancer or cleft palate.

30. for treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

31. for weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in the "Covered Services" section. Weight loss programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
32. for marital counseling.
33. for prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
34. For vision orthoptic training.
35. for hearing aids or examinations for prescribing or fitting them, except as specified in the “Covered Services” section of this Benefit Booklet.
36. For routine vision examinations and refractive services.
37. for services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
38. for reversal of sterilization.
39. for testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis.
40. for personal hygiene, environmental control, or convenience items including but not limited to:
   • air conditioners, humidifiers, air purifiers;
   • physical fitness equipment such as a treadmill or exercise cycles;
   • special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
   • charges from a health spa or similar facility;
   • personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals;
   • charges for non-medical self-care except as otherwise stated;
   • purchase or rental of supplies for common household use, such as water purifiers;
   • hypoallergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
   • infant helmets to treat positional plagiocephaly; safety helmets for Members with neuromuscular diseases; or sports helmets, except when required to treat congenital defects or birth abnormalities of a newborn child.
41. for telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Administrator, on behalf of the Employer.
42. for care received in an emergency room that is not Emergency Care, except as specified in this Benefit Booklet. This includes, but is not limited to, suture removal in an emergency room.
43. for eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
44. for self-help training and other forms of non-medical self care, except as specified in the “Covered Services” section of this Benefit Booklet.
45. for examinations relating to research screenings.
46. for stand-by charges of a Physician.
47. for physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

48. related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

49. for Private Duty Nursing Services.

50. for Manipulation Therapy services rendered in the home as part of Home Care Services.

51. for any New FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

52. for services and supplies related to sex transformation operative procedures, except for Gender Dysphoria Services coverage as defined in this booklet, and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion 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.

53. for elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

54. for Prescription Legend Drugs or Mail Order Drugs.

55. for nutritional and dietary supplements, except as provided in the “Covered Services” section of this Benefit Booklet. This exclusion includes, but is not limited to, those supplements that by law do not require either the written prescription of a Physician or dispensing by a licensed pharmacist. It also includes vitamins and food replacements, such as infant formulas and enteral formulas.

56. Transportation and lodging in connection with human organ and tissue transplant (bone marrow/stem cell) services

57. for (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology (study of the iris), auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.

58. for hiring, or the services of, a surrogate mother.

59. for surgical treatment of gynecomastia.

60. for treatment of hyperhidrosis (excessive sweating).
61. for any service for which you are responsible under the terms of this Benefit Booklet to pay a Coinsurance or Deductible, and the Coinsurance or Deductible is waived by a Non-Network Provider.

62. for Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Administrator, on behalf of the Employer, through Prior Authorization.

63. for services, supplies and equipment for the following:
   - gastric electrical stimulation.
   - hippotherapy.
   - intestinal rehabilitation therapy.
   - prolotherapy.
   - recreational therapy.
   - sensory integration therapy (SIT).

64. for extracorporeal shock wave treatment for plantar fasciitis and other musculoskeletal conditions.

65. for complications directly related to a service or treatment that is a non-Covered Service under the Plan because it was determined by the Administrator, on behalf of the Employer, to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

66. for 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.

67. for sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68. for treatment of telangiectatic dermal veins (spider veins) by any method.

69. services performed by doula or concierge service charges.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Administrator, on behalf of the Employer, determines to be Experimental/Investigative is not covered under the Plan.

The Administrator, on behalf of the Employer, will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Administrator, on behalf of the Employer, 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:

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

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

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

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

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

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Administrator, on behalf of the Employer. In determining whether a Service is Experimental/Investigative, We 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 Administrator, on behalf of the Employer, to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

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

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

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

- documents of an IRB or other similar body performing substantially the same function; or
consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Administrator, on behalf of the Employer, will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

### ELIGIBILITY AND ENROLLMENT

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

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

### Eligibility

The following eligibility rules apply unless you are notified by the Employer.

#### To Be Eligible for Coverage

To be eligible for this coverage, you (the participant) must be:

- A regular faculty member with an appointment of 50% or more of the required full-time faculty workload, or a regular semester-based teaching faculty member on the Danforth campus with a semester appointment of at least 6.5 credit hours.

- A regular staff employee whose standard work schedule is 20 or more hours per week.

- An employee who is permanently disabled.

- A Postdoctoral Research Associate, or a Postdoctoral Research Scholar who is supported by a grant and receives stipend payments from Washington University sufficient to cover the cost of benefits.

- An employee who otherwise meets the eligibility requirements for coverage under the Employer Shared Responsibility provisions of the Affordable Care Act.

New employees or postdoctoral research appointees and their dependents become eligible for this coverage the first of the month coincident with or next following date of hire or postdoctoral appointment start date.

The following are not eligible for this coverage:

- 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 Administrator, on behalf of the Employer, will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.
• A person whose employment is incidental to his or her educational or training program, unless this person has a postdoctoral arrangement with Washington University.

• A leased employee working for Washington University.

• An independent contractor working for Washington University. The independent contractor status is determined by the plan administrator, based on applicable laws and regulations.

• A person performing services for Washington University under an agreement which provides that the person will not be eligible to participate in the benefit plans of Washington University.

**To Remain Eligible for Coverage**

To remain eligible for group coverage:

- You (the participant) must continue to be employed by Washington University or a participating employer or
- You must continue to meet other appropriate eligibility requirement listed above.

**Dependents**

You may enroll family members at the same time you enroll in this plan.

You may also enroll eligible Dependents during a Special Enrollment Period or during the Annual Open Enrollment Period. ("Special Enrollment Period" and "Open Enrollment Period" later in this section.)

Eligible Dependents include:

- Your spouse or Domestic Partner; who resides with you. For purposes of this plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner’s child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

- Your or your spouse’s/Domestic Partner’s children, including natural children, stepchildren, legally adopted children or children placed in your custody for adoption, and children required to be covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

- Children for whom you or your spouse/Domestic Partner has full legal guardianship.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits.

Eligibility will be continued past the age limit only for those already enrolled unmarried Dependents who cannot work to support themselves due to physical or mental handicap. The Dependent’s disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent’s eligibility. The Plan must be informed of the Dependent’s eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must notify the Administrator and/or the Employer if the Dependent’s marital status changes and they are no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child’s coverage.
To obtain coverage for children, the Administrator may require that the Subscriber complete a “Dependency Affidavit” and provide the Administrator and/or the Employer with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under the Plan.

**Enrollment**

**Initial Enrollment**

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Employer. The application must be received within 31 days from the date the person first becomes eligible for coverage. If the initial application is not received by this date, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on Eligible Dependents.

**Newborn and Adopted Child Coverage**

Newborn children of the Subscriber or the Subscriber’s spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days only if the Subscriber submits through the Employer a request to add the child under the Subscriber’s Plan. The request must be submitted 62 days after the birth of the child. Failure to notify the Plan during this period will result in no coverage for the newborn beyond the first 31 days, except as permitted for a Late Enrollee.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

**Adding a Child due to Award of Legal Guardianship**

If a Subscriber or the Subscriber’s spouse is awarded legal guardianship for a child, an application must be submitted within 31 days of the date legal guardianship is awarded by the court. Coverage would start on the date the court granted legal guardianship. If the Employer does not receive an application within the 31-day period, the child will be treated as a Late Enrollee.

**Qualified Medical Child Support Order**

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under the Plan, the Plan will permit your child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of the Plan in accordance with the applicable requirements of such order. A child’s coverage under this...
provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under the Plan will be paid, at the Plan’s discretion, to the child or the child’s custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Employer will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Administrator directly.

Special Enrollment/Special Enrollees

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 the Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage or 62 days after the birth, adoption, or placement for adoption.

If the Employer receives an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, the Employer will not be able to enroll that person until the Employer’s next Open Enrollment.

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) under Medicaid or CHIP.

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If the Employer receives an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, the Employer will not be able to enroll that person until the Employer’s next Open Enrollment.

Open Enrollment Period

Each year during the Open Enrollment period, you have the opportunity to review and change your health care election. Any enrollments or changes made during open enrollment will become effective the following January 1.

An Eligible Person or Dependent who did not enroll for coverage during the initial enrollment period, or during a Special Enrollment period, may enroll during the Employer’s next annual Open Enrollment period.

Notice of Changes

The Subscriber is responsible for notifying the Employer of any changes that will affect his or her eligibility or that of Dependents for services or benefits under the Plan. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare. Failure to notify the Employer of persons no longer
eligible for services will not obligate the Plan to pay for such services. Acceptance of payments from the Employer for persons no longer eligible for services will not obligate the Plan to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the first of the month following date of event causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Employer must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A Member's coverage terminates on the last day of the month in which the Member ceases to be eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

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.

Effective Date of Coverage

Coverage will begin on the first day of the month coincident with or following the date you become eligible for coverage provided you enroll within 31 days of the date you become eligible for coverage.

Statements and Forms

Subscribers must complete and submit on-line or paper applications or other forms or statements the Plan may reasonably request.

Applicants for membership understand that all rights to benefits under the Plan are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a Member may result in termination of coverage as provided in the "Changes in Coverage: Termination and Continuation" section. The Administrator, on behalf of the Employer, will not terminate the Plan on the basis of application misstatements after two years have passed since the Enrollment Date.

Delivery of Documents

The Administrator, on behalf of the Employer, will provide an Identification Card for each Member and a Benefit Booklet upon request.
Termination

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Employer’s specific requirements:

- If you terminate your coverage as a result of a qualifying family status change, termination will generally be effective on the last day of the month in which the qualifying status change occurs.

- Subject to any applicable continuation requirements, if you cease to meet eligibility requirements as outlined in this Benefit Booklet, your coverage generally will terminate on the last day of the month. You must notify the Employer immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you engage in fraudulent conduct or furnish the Plan fraudulent or misleading material information relating to claims or application for coverage, then the Employer may terminate your coverage immediately, retroactive to the date of fraud or material misrepresentation. You are responsible to pay the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Fees paid for such services. On the date your coverage is terminated, the Employer will also terminate your Dependent’s coverage.

- A Dependent’s coverage will generally terminate at the end of the month in which the person no longer meets the definition of Dependent, unless the termination is due to fraud or material misrepresentation as explained above.

- If you elect coverage under another carrier’s health benefit plan which is offered by, through, or in connection with the Employer as an option instead of the Plan, then coverage for you and your Dependents will generally terminate at the end of the month prior to your coverage effective date in the other plan.

- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Fees or contributions in accordance with the terms of the Plan, the Employer may terminate your coverage and may also terminate the coverage of all your Dependents, generally effective immediately upon their written notice to you.

- If you permit the use of your or any other Member’s Plan Identification Card by any other person; use another person’s card; or use an invalid card to obtain services, your coverage will terminate immediately upon written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

Removal of Members

Upon written request through the Employer, a Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member’s termination date.
Continuation

Federal Continuation of Coverage (COBRA)

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

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

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Employer’s health plan when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, the Employer must offer COBRA continuation coverage to each person who is a “qualified beneficiary.” You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Employer’s health plan is lost because of the qualifying event. Under the Employer’s health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Employer for Fee payment requirements.

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

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child’s losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber’s hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Employer’s health plan is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, you and your
entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Employer. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Subscriber or former Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Employer’s health plan had the first qualifying event not occurred.

**Trade Act of 1974**

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

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

**Fees and the End of COBRA Coverage**

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

Continued coverage ends earlier if the plan ends or if the person covered:

- fails to pay Fees timely;
- after the date of election, first becomes covered under another group health plan which contains no pre-existing condition limitations or exclusions;
- after the date of election, first becomes covered under another group health plan which contains a pre-existing condition limitation or exclusion which you have satisfied pursuant to the federal Health Insurance Portability and Accountability Act of 1996, as first enacted or later amended; or
- after the date of election, first becomes entitled to Medicare benefits.
If You Have Questions

Questions concerning your Employer’s health plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. Employers must provide a cumulative total of five years, and in certain instances more than five years, of military leave.

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

During a military leave covered by the Act, the law requires Employers to continue to provide coverage under the Plan for its members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying your Employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and Employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During Military Leave

Continued coverage under USERRA will terminate on the earlier of the following events:

1. The date you fail to return to Active Work with the Employer following completion of your military leave. Employees must return to Active Work within:
   - the first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
   - 14 days after completing military service for leaves of 31 to 180 days,
   - 90 days after completing military service, for leaves of more than 180 days; or
2. 24 months from the date your leave began.
Reinstatement of Coverage Following a Military Leave

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under the Plan if you return within:

- the first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
- 14 days of completing your military service, for leaves of 31 to 180 days; or
- 90 days of completing your military service, for leaves of more than 180 days.

If, due to an Illness or Injury caused or aggravated by your military service, you cannot return to Active Work within the times stated above, you may take up to:

- two years; or
- as soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such Illness or Injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under the Plan. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, the Plan will not provide coverage for any Illness or Injury caused or aggravated by your military service, as indicated in the "Non-Covered Services / Exclusions" section.

Family and Medical Leave Act of 1993

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

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

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

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

**Network Services and Benefits**

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be paid at the Network level and you will not be financially responsible for any Covered Services that the Administrator, on behalf of the Employer, determines is not Medically Necessary. However, regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of Physicians. The Administrator, on behalf of the Employer, determines the Medical Necessity of the service.

The Administrator, on behalf of the Employer, may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the “Your Right To Appeal” section of this Benefit Booklet.

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

For services rendered by Network Providers:

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

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

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

**Non-Network Services**

Services that are not obtained from a PCP, SCP, or another Network Provider or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care and ambulance services.

For services rendered by a Non-Network Provider, you are responsible for:
• The difference between the actual charge and the Maximum Allowable Amount, plus any Deductible and/or Coinsurance;
• Services that are not Medically Necessary;
• Non-Covered Services;
• Filing claims; and
• Higher cost sharing amounts.

**Note:** Except as otherwise noted in this Benefit Booklet, all services covered by a Network Provider are also covered by a Non-Network Provider.

**Relationship of Parties (Plan - Network Providers)**

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

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

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

To be an informed consumer, it is important for you to know what services are covered under the Plan. At times, a Network Provider may recommend that you obtain services that are not covered under the Plan. If a Network Provider clearly informs you that the Plan may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

**Not Liable for Provider Acts or Omissions**

The Plan is not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. The Plan and the Administrator’s Network Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of the Plan. The Plan will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

**Identification Card**

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

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

How Benefits Are Paid

Maximum Allowed Amount

GENERAL

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Non-Network Providers is based on this Booklet’s Maximum Allowed Amount for the Covered Service that You receive. Please see the BlueCard section for additional information.

The Maximum Allowed Amount for this Booklet 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 Booklet and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your 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 Coinsurance. In addition, when You receive Covered Services from a Non-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, We 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 Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, 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, We 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 a Non-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with Us 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 Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Network Providers.

For Covered Services You receive from a Non-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by Us:

1. An amount based on Our Non-Network Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Us, 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 the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or

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

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

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods shown above.

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

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

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

**Member Cost Share**

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

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

We 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 Non-Network Provider. Both services specifically excluded by the terms of your Plan and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

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

**Authorized Services**

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

**Payment of Benefits**

You authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMCSO), as having a right to enrollment under the Employer’s Plan), or that person’s custodial parent or designated representative. Any payments made by the Plan will discharge the Plan’s obligation to pay
for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a “Qualified Medical Child Support Order” as defined by ERISA or any applicable state law.

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

**Services Performed During Same Session**

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

**Assignment**

The Employer cannot legally transfer coverage under the Plan, without obtaining written permission from the Plan. Members cannot legally transfer the coverage. Benefits available under the Plan are not assignable by any Member without obtaining written permission from the Plan, unless in a way described in this Benefit Booklet.

**Claims Review**

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-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**

After you get Covered Services, the Administrator must receive written notice of your claim within 20 days in order for benefits to be paid. The claim must have the information the Administrator needs to determine benefits. If the claim does not include enough information, the Administrator will ask for more details and it must be sent to the Administrator within the time listed below or no benefits will be covered, unless required by law.

If it is not reasonably possible for you to submit your claim within 20 days, you will have some extra time to file a claim. If the Administrator did not get your claim within 20 days, but it is sent in as soon as reasonably possible, you will still be able to get benefits.

**Proof of Loss**

The Administrator must receive proof of loss, including all additional information needed to process your claim, within 90 days after the date of such loss. If it is not reasonably possible for you to submit such proof within 90 days, you will have some extra time to submit such proof. **However, except in**
the absence of legal capacity of the claimant, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to the Administrator, or contact customer service and ask for a claim form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claim form within that time, you will be deemed to have complied with the notice of claim requirements upon submitting, within the time period specified in earlier in this section, written notice of services rendered. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

The Administrator, on behalf of the Employer, will respond to a filed claim within 10 days of its receipt by:

- sending an acknowledgement of the date the Administrator received your claim; or
- sending notice of the status of the claim that includes a request for additional information.

These provisions do not apply if the Administrator, on behalf of the Employer, pays the claim within 10 days after it was received.

Claims submitted by a public (government operated) Hospital or clinic will be paid by the Administrator directly, as long as you have not already received benefit under that claim. The Administrator, on behalf of the Employer, will pay all claims within 30 days after receiving proof of loss. If you are dissatisfied with the Administrator’s denial or amount of payment, You may request that the Administrator, on behalf of the Employer, review the claim a second time, and you may submit any additional relevant information.

Member’s Cooperation

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

You agree (on behalf of yourself and as authorized representative of your enrolled Dependents) to furnish all information required by the Administrator, its affiliates, agents or designees, and that any Provider, insurance or reinsurance company, health services corporation, health maintenance organization, medical information bureau, Medicare fiscal agent, consumer reporting agency, employer
or third party administrator, is authorized and directed to release any and all information relating to history, diagnosis, prognosis, treatment and Covered Services relating to any condition (including but not limited to alcohol/Substance Abuse and HIV) to the Administrator, its affiliates, agents or designees, who are also authorized to receive and release such information in connection with: investigating, evaluating and/or processing claims; utilization, credentialing, quality or medical management programs; managing the provision of services; insurance; and carrying out any other lawful purpose relating to coverage.

This authorization remains valid until expressly revoked by notifying the Administrator, its affiliates, agents or designees in writing of such revocation at any time (except to the extent any action has been taken based on this authorization and/or except as release of such information may be required or authorized by law). Refusal to consent to the release of such information to the Administrator, its affiliates, agents or designees will permit the Plan to deny claims for benefits.

Overpayment of Claims

If the Administrator, on behalf of the Employer, makes any payment to a Provider, to You, or to any other organization that is wholly or partially incorrect under the terms of the Plan, the Administrator, on behalf of the Employer, will seek reimbursement from You, the Provider or other organization to which payment was made. The Administrator, on behalf of the Employer, will not request a refund or offset against a claim more than 12 months after paying the claim, except in cases of fraud or misrepresentation by the Provider. This will apply regardless of the reason for the overpayment. This provision will survive the termination of the Plan.

Explanation of Benefits (EOB)

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

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible (if any).
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Inter-Plan Programs

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of Anthem’s Missouri Service Area, which is all of Missouri except 30 counties in the Kansas City area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.
Typically, when accessing care outside Anthem’s Service Area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating healthcare providers. Anthem’s payment practices in both instances are described below.

**BlueCard® Program**

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

Whenever you access covered healthcare services outside Anthem’s Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

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

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

Federal law or the law 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, We would then calculate your liability for any covered healthcare services according to applicable law.

**Non-Participating Healthcare Providers Outside Anthem’s Service Area**

**Member Liability Calculation**

When covered healthcare services are provided outside of the Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue’s nonparticipating healthcare 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 healthcare provider bills and the payment the Administrator will make for the Covered Services as set forth in this paragraph.
Exceptions

In certain situations, the Administrator may use other payment bases, such as billed covered charges, the payment the Administrator would make if the healthcare services had been obtained within the Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Administrator will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the 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 Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card or go to www.anthem.com for more information about such arrangements.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Employer or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 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 health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

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

Payment Details

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

**Claim Filing**

• The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.

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

**Claim Forms**

You can get international claim forms from the Administrator, the BlueCard Worldwide Service Center, or online at [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide). The address for sending in claims is on the form.

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**Health Care Management**

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

If you have any questions regarding the information contained in this section, you may call the Precertification telephone number on the back of your membership card or visit [www.anthem.com](http://www.anthem.com).

**Types of Requests:**

**Precertification** – a request for service, treatment or admission that requires a benefit coverage determination be obtained prior to the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or physician must notify the Administrator within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

**Predetermination** – a prospective request for a benefit coverage determination for a service, treatment or admission that does not require Precertification. Predetermination reviews will review your coverage to determine whether the service, treatment or admission is an exclusion under your Benefit Booklet. 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 your Benefit Booklet or is Experimental/Investigative as that term is defined under your Benefit Booklet.
**Medical Review** – a Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which the Administrator, on behalf of the Employer, has a related clinical coverage guideline and are typically initiated by the Administrator.

Most Network Providers know which services require Precertification and will obtain any required Precertification or request a Predetermination if they feel it is necessary. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. Generally, the ordering Provider, facility or attending Physician will contact the Administrator to request a Precertification or Predetermination review (“requesting Provider”). The Administrator, on behalf of the Employer, will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years or older.

<table>
<thead>
<tr>
<th>Who is responsible for Precertification</th>
<th>Services provided by a BlueCard/Non-Network/Non-Participating Provider</th>
</tr>
</thead>
</table>
| Services provided by a Network Provider| • Member is responsible for Precertification.  
• Member is financially responsible for service and/or setting that are/is not covered under this Benefit Booklet based on an Adverse Determination of Medical Necessity or Experimental/Investigative. |

The Administrator, on behalf of the Employer, will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventative care clinical coverage guidelines, to assist in making its medical necessity decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. The Administrator, on behalf of the Employer, reserves the right to review and update these clinical coverage guidelines periodically. Your Benefit Booklet and Group contract take precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, contact the Precertification telephone number on the back of your membership card.

**Request Categories:**

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

- **Prospective** – a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.

- **Concurrent** - a request for Precertification or Predetermination that is conducted during the course of treatment or admission.
**Retrospective** - a request for Precertification that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

**Decision and Notification Requirements**

Timeframes and requirements listed are based on Federal regulations. You may call the telephone number on the back of your membership card for additional information.

<table>
<thead>
<tr>
<th>Request Category</th>
<th>Timeframe Requirement for Decision and Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective Urgent</td>
<td>72 hours from the receipt of request</td>
</tr>
<tr>
<td>Prospective Non-Urgent</td>
<td>15 calendar days from the receipt of the request</td>
</tr>
<tr>
<td>Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization</td>
<td>24 hours from the receipt of the request</td>
</tr>
<tr>
<td>Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists</td>
<td>72 hours from the receipt of the request</td>
</tr>
<tr>
<td>Concurrent Non-Urgent</td>
<td>15 calendar days from the receipt of the request</td>
</tr>
<tr>
<td>Retrospective</td>
<td>30 calendar days from the receipt of the request</td>
</tr>
</tbody>
</table>

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

The Administrator, on behalf of the Employer, 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) premium must be paid for the time period that services are rendered; 
3) the service or surgery must be a covered benefit under your Benefit Booklet; 
4) the service cannot be subject to an exclusion under your Benefit Booklet, including but not limited to a preexisting condition limitation or exclusion; and 
5) you must not have exceeded any applicable limits under your Benefit Booklet.

**Care Management**

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

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

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

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

**Value-Added Programs**

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

**12 YOUR RIGHT TO APPEAL**

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the plan. The term includes both pre-service and post-service claims.
• A pre-service claim is a claim for benefits under the plan for which you have not received services 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.

• You will be provided with a written notice of the denial; and

• You are entitled to a full and fair review of the denial.

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 Administrator’s notice of 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 Administrator’s decision is based;

• a description of any additional material or information needed to perfect your claim;

• an explanation of why the additional material or information is needed;

• a description of the plan’s review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;

• information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim decision 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 decision based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.

For claims involving urgent/concurrent care:

• the Administrator’s notice will also include a description of the applicable urgent/concurrent review process; and

• the 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. You or your authorized representative must ask for an appeal within 180 calendar days after you are notified of a denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Administrator’s review of your appeal will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit decision.

The Administrator offers a mandatory level of appeal. The timeframe allowed for the 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 request an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Administrator’s decision, can be sent between the Administrator and you by phone, fax or other similar method. To ask for an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Administrator by calling 1-800-325-3377 or fax the request to 1-877-333-7488. If you prefer, you can send your request in writing to: Anthem Blue Cross and Blue Shield, Grievances and Appeals, 3536 East Sunshine, Suite 132, Springfield, MO 65809. 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 handled on an expedited basis.

All other requests for appeals should be sent in writing by you or your authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). Send written appeals to: Anthem Blue Cross and Blue Shield, Attn: Grievances and Appeals, P.O. Box 105568, Atlanta, GA 30348-5568. You must include your member ID number when submitting an appeal. Upon request, the 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 decisions 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 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 Administrator will provide you, free of charge, with the rationale.
Appeal Review

When the Administrator considers your appeal, the Administrator will not rely upon the initial benefit 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.

Notification of Appeal Outcome

If you appeal a claim involving urgent/concurrent care, the 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, Washington University will notify you of the outcome of the appeal within 15 days after receipt of your appeal request.

If you appeal a post-service claim, Washington University will notify you of the outcome of the appeal within 30 days after receipt of your appeal request.

Appeal Denial

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

Mandatory Second Level Appeals

If you are not satisfied with the Administrator’s first level appeal decision, a mandatory second level appeal is available. If you would like to ask for a mandatory second level appeal, please write to Washington University Attn: Health Plan Appeals, 7509 Forsyth, Suite 150, St. Louis, MO 63105. If you prefer, you can fax your request to 314-935-8198. Your request must be submitted within 60 calendar days of the denial of the first level appeal.

If your second level appeal is for a pre-service claim, Washington University will notify you of the outcome of the appeal within 15 days after receipt of your appeal request.

If your second level appeal is for a post-service claim, Washington University will notify you of the outcome of the appeal within 30 days after receipt of your appeal request.

External Review

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

You must submit your request for External Review to the Administrator within four months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the 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 Administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Administrator's decision, can be sent between the Administrator and you by phone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Administrator at the phone number on your member ID 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 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: Grievances and Appeals, P.O. Box 105568; Atlanta, GA 30348-5568. You must include your member ID number when submitting a request for external review.

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

13 GENERAL PROVISIONS

Entire Contract

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

Form or Content of Benefit Booklet

No agent or employee of the Plan is authorized to change the form or content of this Benefit Booklet. Changes can only be made through a written authorization, signed by a person authorized to sign on behalf of the Employer.
Disagreement with Recommended Treatment

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

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

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include, but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Plan, disability affecting a significant number of a Network Provider's staff or similar causes, or health care services provided under the Plan are delayed or considered impractical. Under such circumstances, the Plan and Network Providers will provide the health care services covered by the Plan as far as is practical under the circumstances, and according to their best judgment.

Protected Health Information Under HIPAA

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

Coordination of Benefits

Applicability

This coordination of benefits (COB) provision applies to this plan when an employee or the employee's covered Dependent has health care coverage under more than one plan. “Plan” and “this plan” are defined here.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:
• will not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but
• may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is defined in "Effect on the Benefits of this Plan" below.

Definitions
“Plan” is any of those that provides benefits or services for, or because of, medical or dental care or treatment:

  Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

  Coverage under a governmental plan, or coverage required or provided by law. This does not include Medicare Part B or Part D or a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time-to-time). Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

  “This plan” is the part of the group contract that provides benefits for health care expenses.

  “Primary plan/secondary plan”: The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan’s benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan’s benefits. When there are more than two plans covering the person, this plan may be a primary plan to one or more other plans, and may be a secondary plan as to a different plan(s).

  “Allowable expense” means a necessary, reasonable and customary item of expense for health care; when the items of expense are covered at least in part by one or more plans covering the person for whom the claim is made. “Allowable expense” is limited to like items of expense, such that medical expenses will only coordinate with other medical expenses. The difference between the cost of a private room in a hospital and the cost of a semi-private room in a hospital is not considered an allowable expense under this definition unless the patient’s stay in a private room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of that reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, Precertification of admissions or services, and preferred Provider arrangements.

  “Claim determination period” means a calendar year. However, it does not include any part of a year during which a person is not covered under this plan, or any part of a year before the date this COB provision or similar provision takes effect.

Order of Benefit Determination Rules
When there is a basis for a claim under this plan and another plan. This plan is a secondary plan that has its benefits determined after those of the other plan, unless:

1. the other plan has rules coordinating its benefits with those of this plan; and
2. both those rules and this plan’s rules, outlined below, require that this plan’s benefits be determined before those of the other plan.

This plan determines its order of benefits using the first of the following rules which applies:

1. Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that; if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   a. secondary to the plan covering the person as a dependent; and
   b. primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

2. Dependent child/parents not separated or divorced. Except as stated in the definition of “Primary plan/secondary plan”, when this plan and other plan cover the same child as a dependent of different persons, called parents:
   a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
   b. If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plans that covered the other parent for a shorter period of time. However, if the other plan does not have the rule described previously and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent child/separated or divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the plan of the parent with custody of the child;
   b. Then, the plan of the spouse of the parent with the custody of the child; and
   c. Finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Joint custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health Care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in 3. above.

5. Active/inactive employee. The benefits of a plan that covers a person as an employee who is neither laid off nor retired are determined before those of a plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:

   a. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person’s dependent);

   b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described here and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan that covered an employee, member or subscriber longer are determined before those of the plan that covered that person for the shorter term.

Effect on the benefits of this plan

This section applies when, in accordance with the “Order of Benefit Determination Rules” above, this plan is a secondary plan as to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plans(s) are referred to as the other plans below.

The benefits of this plan will be reduced when the sum of:

- The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and

- The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceed those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. When the benefits of this plan are reduced as described previously, each benefit is in proportion. It is then charged against any applicable benefit maximum of this plan.

Right to receive and release needed information

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to pay the claim.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, the Plan may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under this plan. The 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 reasonable cash value of the benefits provided in the form of services.
Medicare

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

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

Workers’ Compensation

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

Other Government Programs

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

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

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

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
• You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan’s rights and do nothing to prejudice those rights.

• In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

• The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

• To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan’s subrogation claim and any claim held by you, the Plan’s subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

• The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan’s prior written consent. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

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

• You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

• Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan’s rights will not be reduced due to your negligence.

• You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

• If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

• In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan’s lien from any future benefit under the Plan.
• The Plan shall also be entitled to recover any of the unsatisfied 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.

• The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

**Your Duties**

• You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.

• You must cooperate with the Plan in the investigation, settlement and protection of the Plan’s rights. In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

• You must not do anything to prejudice the Plan’s rights.

• You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

• You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

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

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

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

**Right of Reservation**

Regardless of any election made by a Member, the coverage under the Plan pays secondary to a No-Fault/Personal Injury Protection policy.

**Right of Recovery**

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 12 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such recovery activity.
The Administrator, on behalf of the Employer, has oversight responsibility for compliance with Provider, vendor and Subcontractor contracts. The Administrator, on behalf of the Employer, may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor or Subcontractor resulting from these audits if the return of the overpayment is not feasible. The Administrator, on behalf of the Employer, has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Administrator, on behalf of the Employer, will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Administrator, on behalf of the Employer, may not provide you with notice of overpayments made by the Plan or you if the recovery method makes providing such notice administratively burdensome.

**Relationship of Parties (Employer-Member Plan)**

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

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

**Important Note**

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Booklet and Administrative Services Agreement constitutes a contract solely between the Employer and the Administrator, which is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in its Missouri service area. 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, the Administrator 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 the Administrator other than those obligations created under other provisions of this agreement.

**Conformity with Law**

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

**Clerical Error**

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

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

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

Medical Policy and Technology Assessment

Anthem 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 / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem’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 Anthem’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.

Waiver

No agent or other person, except an authorized officer of the Plan, is able to disregard any conditions or restrictions contained in this Benefit Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Additional Benefits

The Plan may cover services and supplies not specifically covered by the Plan. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve appeal 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. The Administrator has complete discretion to interpret the Benefit Booklet. The Administrator’s determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether
charges are consistent with the Plan’s Maximum Allowable Amount. A member may utilize all applicable appeals procedures.

The Employer has the discretion to interpret any vague or ambiguous term or provision in favor of the Plan’s Reimbursement rights.

DEFINITIONS

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

If you need additional clarification on any of these definitions, please contact the customer service number located on the back of your ID Card.

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

**Administrator** – An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator is RightCHOICE Managed Care, Inc. d/b/a Anthem Blue Cross and Blue Shield. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

**Benefit Booklet** – This summary of the terms of your health benefits.

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

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

**Coinsurance** - A specific percentage of the Maximum Allowable Amount for Covered Services indicated in the Schedule of Benefits that you must pay. Coinsurance normally applies after the Deductible, if applicable, that you are required to pay. See the Schedule of Benefits for any exceptions. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

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

- Medically Necessary or otherwise specifically included as a benefit under the Plan.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
• Not Experimental/Investigative or otherwise excluded or limited by this Benefit Booklet, or by any
amendment or rider thereto.

• Authorized in advance by the Administrator, on behalf of the Employer, if such Prior Authorization
is required in this Benefit Booklet.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided
to you.

The incurred date (for determining application of Deductible and other cost share amounts) for an
Inpatient admission is the date of admission except as otherwise specified in “Extension of Benefits”.
Covered Services do not include any services or supplies that are not documented in Provider records.

**Covered Transplant Procedure** – Any Medically Necessary human organ and bone marrow / stem cell transplant / transfusion as determined by the Administrator, on behalf of the Employer,
including necessary acquisition procedures, harvest and storage, and including Medically Necessary
preparatory myeloblastic therapy.

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

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

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

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

**Dependent** – A member of the Subscriber's family who is covered under the Plan, as described in
the "Eligibility and Enrollment" section.
**Domestic Partner** - A person of either gender to whom the Subscriber is not legally married, but who lives with the Subscriber in a non-platonic relationship and with whom the Subscriber has an emotional and financial commitment. The Subscriber must complete a Domestic Partner Declaration and provide proof of residence for the Domestic Partner to the Employer.

**Effective Date** – The date that a Subscriber’s coverage begins under the Plan. A Dependent’s coverage also begins on the Subscriber’s Effective Date, unless otherwise specified.

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

**Emergency (Emergency Medical Condition)** – An accidental bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity that the absence of immediate medical attention could be reasonably expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- place the person’s health in significant jeopardy;
- result in serious impairment to a bodily function;
- result in serious dysfunction of any bodily organ or part;
- result in inadequately controlled pain; or
- with respect to a pregnant woman who is having contractions:
  1. believe that there is inadequate time to effect a safe transfer to another Hospital before delivery; or
  2. believe that transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

**Emergency Care** – A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.

**Employer** – Washington University in St. Louis.

**Employer Network Provider** - A Network Provider facility who contracts with the Administrator and whose services are billed by the Employer. Employer Network Provider also includes all other professional Network Providers contracted with the Administrator and the Employer.

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

**Experimental/Investigative** – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other
facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

The Plan may consult with professional peer review committees or other appropriate sources for recommendations.

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

**Fees** – The periodic charges that must be paid by you and/or the Employer to maintain benefits under the Plan.

**Grievance Advisory Panel** - A panel consisting of other enrollees; the Administrator’s representatives who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance; and, where the grievance involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

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

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

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

**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.

**Medically Necessary or Medical Necessity** - Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. The Plan may consult with professional peer review committees or other appropriate sources for recommendations.

Services must also be 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.

**Medicare** – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

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

**Mental Health and Substance Abuse**

- **Mental Illness** – Any conditions or disorders classified as mental disorders in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
• **Substance Abuse** – The psychological or physiological dependence upon or abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and the impairment of social or occupational role functioning or both.

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

**Network Transplant Provider** – A Provider that has been designated as a “center of excellence” by the Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to:

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

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

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

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

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

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

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

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

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

• **Alternative Care Facility** - A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:
1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
2. Surgery
3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility, with an organized staff of Physicians, that:
  1. is licensed as such, where required;
  2. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  3. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  4. does not provide Inpatient accommodations; and
  5. is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Certified Advance Registered Nurse Practitioner**
- **Certified Nurse Midwife** - When services are supervised and billed for by an employer Physician.
- **Certified Registered Nurse Anesthetist** - When services are performed in collaboration with a Physician and billed by a certified facility or Hospital.
- **Certified Surgical Assistant**
- **Chiropractor**
- **Community Mental Health Center** - A legal entity certified by the Department of Mental Health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals.
- **Day Hospital** - A facility that provides day rehabilitation services on an Outpatient basis.
- **Dialysis Facility** - A facility that mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.
- **Home Health Care Agency** - A facility, licensed in the state in which it is located, which:
  1. provides skilled nursing and other services on a visiting basis in the Member's home; and
  2. is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Home Infusion Facility** - A facility which provides a combination of:
  1. Skilled nursing services
  2. Prescription Drugs
  3. Medical supplies and appliances

  in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service by or under the supervision of graduate Registered Nurses on call or on duty;
  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

  1. nursing care
  2. rest care
  3. extended care
  4. convalescent care
  5. care of the aged
  6. Custodial Care
  7. educational care
  8. treatment of mental illness
  9. treatment of alcohol or drug abuse

- **Laboratory (Clinical)**
- **Licensed Marital and Family Therapist**
- **Licensed Mental Health Professional** – A licensed Physician specializing in the treatment of Mental Illness and/or Substance Abuse, a licensed Psychologist, a licensed clinical Social Worker or a Licensed Professional Counselor.
- **Licensed Practical Nurse** – When services are supervised and billed for by an employer Physician.
- **Licensed Professional Counselors**
- **Occupational Therapist**
• **Pharmacy** - An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician’s order. A Pharmacy may be a Network Provider or a Non-Network Provider.

• **Physical Therapist**

• **Physician (Doctor)** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or ophthalmologist (eye and sight specialist).

• **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

• **Registered Nurse First Assistant** - When services are supervised and billed for by an employer Physician.

• **Registered Nurse** - When services are supervised and billed for by an employer Physician.

• **Registered Nurse Practitioner**

• **Regulated Physician’s Assistant** - When services are supervised and billed for by an employer Physician.

• **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

• **Respiratory Therapist (Certified)**

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

• **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. provides care supervised by a Physician;
  3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
  4. is not a place primarily for care of the aged, Custodial or domiciliary care, or treatment of alcohol or drug dependency; and
  5. is not a rest, educational, or custodial Provider or similar place.

• **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.

• **Speech Therapist**

• **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**
• **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

**Service Area** – The geographical area where Our Covered Services are available.

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

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

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

**Spouse** – The Person to whom a Subscriber is legally married.

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

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

**Subcontractor** – The Administrator and/or the Employer may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Administrator’s or Employer’s behalf.

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

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

**Total Disability (or Totally Disabled)** – A Subscriber or a Dependent who had been actively working is considered Totally Disabled if the Member is unable to perform the material and substantial duties of his or her occupation for a period of at least 12 months.

A retiree or a Dependent who had not been actively working is considered Totally Disabled if he or she is unable, because of an illness or injury, to perform the usual and ordinary activities of a person of like age. (In any of these situations, the disability may be either permanent or temporary.)

**We, Us, Our** - Please refer to the definition of "Administrator" above.
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