HOPE GAS, INC. HEALTH AND WELFARE BENEFIT PLAN

MEDICAL PLAN

SUMMARY PLAN DESCRIPTION

FOR

EMPLOYEES REPRESENTED

BY

THE UNITED GAS WORKERS' UNION,

LOCAL 69,

UWUA, AFL-CIO

Effective January 1, 2026

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I. INTRODUCTION

The Medical Plan under the Hope Gas, Inc. Health and Welfare Benefit Plan (the "**Health and Welfare Benefit Plan**") provides Eligible Employees of Hope Gas, Inc. (the "**Company**") and their Eligible Dependents with benefits for covered Medical services under the Medical Coverage Option that you select from the following:

Medical Coverage Options	
Medical Coverage Option A	Anthem Blue Cross and Blue Shield PPO Essential Plan
Medical Coverage Option B	Anthem Blue Cross and Blue Shield PPO Essential Plan With HSA
Medical Coverage Option C	Anthem Blue Cross and Blue Shield PPO Premium Plan
Medical Coverage Option D	Anthem Blue Cross and Blue Shield PPO Premium Plan With HSA
Medical Coverage Option E	Peak Health Plan

ANTHEM BENEFIT BOOKLET

Medical Coverage Options A, B, C and D are provided by Anthem BlueCross BlueShield and administered by Community Insurance Company, and are subject to the terms and conditions of the Anthem Blue Access PPO Benefit Booklet for the Medical Plan (as may be amended from time to time, the "**Anthem Benefit Booklet**"), which constitutes and forms a part of the Medical Plan. A copy of the Anthem Benefit Booklet is available at www.anthem.com or by contacting Hope Gas Benefits.

If you elect Medical Coverage Option A, B, C or D, it is important that you review the Anthem Benefit Booklet in conjunction with this Medical SPD.

PEAK HEALTH CERTIFICATE OF COVERAGE

Medical Coverage Option E is provided and administered by Peak Health, and is subject to the terms and conditions of the Peak Health Certificate of Coverage for the Medical Plan (as may be amended from time to time, the "**Peak Health Certificate of Coverage**"), which constitutes and forms a part of the Medical Plan. A copy of the Peak Health Certificate of Coverage mypeak.peakhealth.org or by contacting Hope Gas Benefits.

If you elect Medical Coverage Option E, it is important that you review the Peak Health Certificate of Coverage in conjunction with this Medical SPD.

SUMMARY PLAN DESCRIPTION

The Summary Plan Description for the Medical Plan consists of this Medical Plan Summary Plan Description (the "**Medical SPD**") and the Additional Information Summary Plan Description for Employees Represented by the United Gas Workers' Union, Local 69, UWUA, AFL-CIO (the "**Additional Information SPD**").

This Medical SPD describes the provisions of the Medical Plan for eligible employees of the Company who are represented by the United Gas Workers' Union, Local 69, UWUA, AFL-CIO. The provisions of the Medical Plan for eligible employees of the Company who are not represented by the United Gas Workers' Union, Local 69, UWUA, AFL-CIO are described in a separate document.

Benefits described in this Medical SPD are as in effect on January 1, 2026. The Company may subsequently provide additional materials that supplement, update or amend the Medical SPD or the Additional Information SPD.

MEDICAL PLAN HIGHLIGHTS

ELIGIBILITY	Employees of the Company who are: • Represented by the United Gas Workers Union Local 69, UWUA, AFL-CIO; and • Regularly scheduled to work an average of 30 hours or more per week.
ENROLLMENT	□ Within 31 days after satisfying the eligibility requirements; or □ If Medical coverage is not elected within 31 days after initial eligibility, enrollment may be elected during the annual Open Enrollment period or upon a Qualifying Life Event.
WHEN COVERAGE BEGINS	□ If enrollment is elected within 31 days of eligibility, coverage is effective as of the eligibility date (e.g. employment date). □ If enrollment is not elected within 31 days of eligibility but is elected during an annual Open Enrollment period, coverage is effective as of January 1st following Open Enrollment.
COST OF COVERAGE	• If Medical coverage is elected, the Company contributes to the cost of coverage and the employee portion of the cost of coverage is deducted from each payroll before federal income tax and, in most cases, before state income tax and Social Security tax are withheld. • The cost of coverage for each Medical Coverage Option may vary from year to year.
FUNDING	• The Medical Plan is self-funded and benefits are funded by the Company.
PLAN YEAR	□ The Plan Year for the Medical Plan is the 12-month period beginning January 1st and ending the following December 31st.

II. ELIGIBILITY

ELIGIBLE EMPLOYEES

Regular full-time employees of the Company who are regularly scheduled to work an average of 30 hours or more per week and are represented by the United Gas Workers' Union Local 69, UWUA, AFL-CIO are eligible to enroll for Medical coverage (an "**Eligible Employee**").

ELIGIBLE DEPENDENTS

An Eligible Employee may enroll their Eligible Dependents for Medical coverage. "**Eligible Dependents**" include:

- **Spouse:** an Eligible Employee's legally married spouse or domestic partner.
- **Children**: an Eligible Employee's Children include the following, in each case who is under age 26: (i) natural children, (ii) legally adopted children (including children placed with an Eligible Employee for adoption), (iii) step-children, (iv) foster children, (v) children for whom the Eligible Employee or their Spouse is required to provide coverage pursuant to a Qualified Medical Child Support order or similar order by a court of competent jurisdiction, and (vi) any other child who

lives with the Eligible Employee in a parent/child relationship and qualifies as the Eligible Employee's dependent as defined in the Internal Revenue Code.

- **Incapacitated Children:** an Eligible Employee's Children (as defined above) who prior to age 26 became continuously incapable of self-sustaining employment by reason of physical, developmental or intellectual disability or by reason of mental illness.

DEPENDENT ELIGIBILITY VERIFICATION AND UPDATES

You are required to notify the Plan Administrator of any changes that affect your eligibility or your Eligible Dependents' eligibility for coverage under the Medical Plan, including but not limited to eligibility under Medicare or under another employer's medical plan.

The Plan Administrator may require, upon request, written proof to reasonably verify a dependent's eligibility under the Medical Plan, such as a marriage certificate, birth certificate, adoption certificate and federal tax returns.

III. ENROLLMENT

NEW HIRE

You can enroll for Medical coverage at any time within 31 days after becoming an Eligible Employee. If you enroll during this initial enrollment period, your coverage will be effective as of the first day of the month coinciding with or next following the date you became an Eligible Employee.

ID CARDS

After you enroll for medical coverage, you will be provided with an Identification Card by Anthem or Peak Health, as applicable, for the Medical Coverage Option you have elected.

OPEN ENROLLMENT

If you do not enroll for Medical coverage within 31 days after becoming an Eligible Employee, or if you did enroll during this period but wish to change your Medical Coverage Option, you may do so during the annual Open Enrollment period, which takes place each year during the fourth quarter.

Coverage elections during the Open Enrollment period are effective as of January 1st of the following year.

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event, you are permitted to change your Medical coverage elections during the middle of a plan year without waiting until the next Open Enrollment period; provided, that you submit to the Plan Administrator written notice within 31 days after the Qualifying Life Event.

An event will be considered a "**Qualifying Life Event**" if it affects your eligibility or your Eligible Dependents' eligibility, including:

- Marriage or registration of domestic partnership;
- Divorce, dissolution of domestic partnership or death of your Spouse;
- Change in your Spouse's employment or eligibility status;
- A change in the number of your Children (birth, adoption, etc.);
- Loss of eligibility or exhaustion of COBRA benefits under a prior medical plan; or
- Loss of employer contributions towards the cost of medical coverage under another employer medical plan.

MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) SPECIAL ENROLLMENT

You and your Eligible Dependents may also enroll for Medical coverage during the middle of a plan year without waiting until the next Open Enrollment period by providing written notice to the Plan Administrator

within 60 days of the following:

- You or your Eligible Dependent lose Medicaid or Children's Health Insurance Program (CHIP) coverage due to loss of eligibility; or
- You or your Eligible Dependent become eligible for a subsidy (state premium assistance program).

QUALIFIED MEDICAL CHILD SUPPORT ORDER

You may enroll your Eligible Dependent Child for Medical coverage during the middle of a Plan Year without waiting until the next Open Enrollment Period, if you or your Spouse become required by a qualified medical child support order ("**QMCSO**") or similar court order under applicable law to provide such child with medical coverage.

A QMCSO is a legal judgment, decree or order that directs a welfare benefit plan (e.g., medical, dental and vision) to cover a child or children of a participant. For example, if you become legally separated or divorced, the terms of your divorce or separation may include a QMCSO requiring you to obtain coverage for one or more of your children.

If you or your Spouse are required to provide medical coverage to a child or children pursuant to a QMCSO, please request a copy of the Health and Welfare Benefit Plan's QMCSO procedures from the Plan Administrator. The Plan Administrator will undertake a review of a QMCSO as soon as practicable, and will comply to the full extent required under applicable law.

ENROLLMENT OPTIONS

Your Medical coverage enrollment options are:

- Employee only;
- Employee and Spouse;
- Employee and Eligible Dependent Child (including an Incapacitated Children)
- Employee and Eligible Dependent Children (including Incapacitated Children); or
- Employee and Eligible Dependents (Spouse + Eligible Dependent Children)

ENROLLMENT PROCESS

You can enroll for Medical coverage by accessing the ADP MyLife Advisors resource website for the Health and Welfare Benefit Plan at **https://mylife-ts.adp.com** or by calling ADP MyLife Advisors at (855) 547-8508. You can also obtain benefit information and receive other information by accessing the website. For assistance with enrollment, contact Hope Gas Benefits:

Hope Gas, Inc. Benefits
781 Chestnut Ridge Road, Suite 100
Morgantown, WV 26505
(304) 566-2959
Samantha.j.baxter-nard@hopegas.com

After you have enrolled for Medical coverage, you will be issued an identification card for the Medical Coverage Option you have elected.

IV. MEDICAL COVERAGE COSTS

If you elect Medical coverage, the employee portion of the cost of coverage will be deducted from your pay each payroll period on a before-tax basis for federal income tax and, in most cases, on a before-tax basis for state income tax and Social Security tax.

The Company will pay a portion of the cost of Medical coverage. The costs of Medical coverage, including the employee portion and Company portion, are set forth on Appendix 1 and are subject to change from year-to-year.

V. MEDICAL BENEFITS

Each of the five Medical Coverage Options available under the Medical Plan provides access to a Preferred Provider Organization ("**PPO**") network, which is a group of health care providers who have agreed to accept negotiated fees as payment for covered medical services.

Under each of the Medical Coverage Options, you may receive Covered Services from an In-Network Provider (that is, a provider who part of the PPO network), or from an Out-of-Network Provider.

COVERED MEDICAL SERVICES

Schedules of Covered Medical Services for each Medical Coverage Option, including applicable Co-Pay and coinsurance amounts, are set forth on the following appendices:

Medical Coverage Option A	Anthem Blue Cross and Blue Shield PPO Essential Plan	Appendix A
Medical Coverage Option B	Anthem Blue Cross and Blue Shield PPO Essential Plan With HSA	Appendix B
Medical Coverage Option C	Anthem Blue Cross and Blue Shield PPO Premium Plan	Appendix C
Medical Coverage Option D	Anthem Blue Cross and Blue Shield PPO Premium Plan With HSA	Appendix D
Medical Coverage Option E	Peak Health Plan	Appendix E

FOR FURTHER INFORMATION AND DETAILS ON COVERED MEDICAL SERVICES, PLEASE REFER TO THE ANTHEM BENEFIT BOOKLET FOR MEDICAL COVERAGE OPTIONS A, B, C AND D, AND THE PEAK HEALTH CERTIFICATE OF COVERAGE FOR MEDICAL COVERAGE OPTION E.

EXCLUDED SERVICES

For a listing of certain procedures, equipment, services, supplies and changes that are excluded from coverage under the Medical Plan:

If you have elected Medical Coverage Option A, B, C or D, please refer to Appendix 2; and

If you have elected Medical Coverage Option E, please refer to Appendix 3.

IN-NETWORK PROVIDERS

Covered Medical Services from an In-Network Provider are at in-network rates. An In-Network Provider will submit your claims directly to Anthem or Peak Health, as applicable, for payment under the Medical Plan; however, you will be responsible for payment of any deductible, Co-Pay or coinsurance to the provider.

If you have chosen Medical Coverage Option A, B, C or D, your In-Network coverage is through the Anthem PPO network. To access a directory of Anthem's In-Network Providers, go to www.anthem.com.

If you have chosen Medical Coverage Option E, your In-Network coverage is through the Peak Health PPO network. To access a directory of Peak Health's In-Network Providers, go to www.peakhealth.org.

OUT-OF-NETWORK PROVIDERS

If you choose to receive Covered Medical Services from an Out-of-Network Provider, the provider is not required to submit claims directly to Anthem or Peak Health, as applicable. You will be responsible for payment to the provider of the full amount of charges for the services, and may then submit a claim to the Medical Plan for reimbursement, subject to applicable deductible, Co-Pay and coinsurance.

PRIMARY CARE PHYSICIAN

You may choose to designate a Primary Care Physician ("**PCP**"), which is a physician who gives or directs health care services for you or your Eligible Dependent. Your PCP may work in family practice, general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan.

If you have elected Medical Coverage Option A, B, C or D, please go to www.anthem.com for a list of Anthem PCPs and information on selecting a PCP.

If you have elected Medical Coverage Option E, please go to mypeak.peakhealth.org for a list of Peak Health PCPs and information on selecting a PCP.

PREVENTIVE CARE

Preventive care is an important part of keeping you and your family healthy. Preventive care includes screenings, immunizations, pediatric vaccines, preventive services required by the Affordable Care Act or applicable state law, and other services for adults and children. All five Medical Coverage Options offer preventive care benefits. In general, preventive care services from In-Network Providers are not subject to deductible or coinsurance.

EMERGENCY SERVICES AND SPECIALTY CARE

In the event of a medical emergency, you should go to the nearest appropriate medical provider or medical service facility. If the provider or facility is not an In-Network Provider, precertification of emergency medical services is not required, and you or your physician can contact Anthem or Peak Health, as applicable, to have the Out-of-Network services authorized for the highest level of benefits.

In the event specialty medical care is required and it is not available from an In-Network Provider, your In-Network primary care physician can contact Anthem or Peak Health, as applicable, in advance to request that the Out-of-Network services be authorized for the highest level of benefits.

ADDITIONAL PROVISIONS AND LIMITATIONS ON COVERED MEDICAL SERVICES

For additional information on Covered Medical Services, including pre-certification of benefits, details on Covered Medical Services, services that are excluded from coverage under the Medical Plan, coverage for medical services outside the United States and other important provisions and limitations, please refer to the Anthem Benefit Booklet for Medical Coverage Options A, B, C or D, and the Peak Health Certificate of Coverage for Medical Coverage Option E.

DEDUCTIBLE

Benefits for Covered Services are subject to payment of a deductible, as follows:

Medical Coverage Option	In-Network Deductible (Includes Pharmacy Deductible for Covered Prescription Drug Benefits)		Out-of-Network Deductible (Includes Pharmacy Deductible for Covered Prescription Drug Benefits)
Option A	$1,500 individual $3,000 family		$1,500 individual $3,000 family
Option B	$5,000 individual $10,000 family		$5,000 individual $10,000 family
Option C	$750 individual $1,500 family		$750 individual $1,500 family
Option D	$3,200 individual $6,400 family		$3,200 individual $6,400 family
	Enhanced Network Deductible	**Standard Network Deductible**	**Out-of-Network Deductible**
Option E	$0 individual $0 family	$3,000 individual $6,000 family	$6,000 individual $12,000 family

COPAYMENTS AND COINSURANCE

Benefits for certain Covered Medical Services may be subject to a Co-Pay and/or coinsurance, which you are responsible for, up to the annual Out-of-Pocket Maximum. Co-Pay and coinsurance amounts may vary under each Medical Coverage Option, and may be different for In-Network services and Out-of-Network services.

The applicable Co-Pay and coinsurance amounts for Medical Coverage Options A, B, C, D and E are set forth on the applicable Appendix A-E and are subject to change from year-to-year.

OUT-OF-POCKET MAXIMUM

Benefits for Covered Medical Services are subject to an annual Out-of-Pocket Maximum for the combined amount of deductible, Co-Pay and coinsurance as follows:

Medical Coverage Option	In-Network Out-of-Pocket Maximum (Includes Pharmacy Out-of-Pocket Maximum for Covered Prescription Drug Benefits)	Out-of-Network Out-of-Pocket Maximum (Includes Pharmacy Out-of-Pocket Maximum for Covered Prescription Drug Benefits)
Option A	$5,000 individual $10,000 family	$10,000 individual $20,000 family
Option B	$6,900 individual $13,800 family	$13,800 individual $27,600 family

Medical Coverage Option	In-Network Out-of-Pocket Maximum (Includes Pharmacy Out-of-Pocket Maximum for Covered Prescription Drug Benefits)		Out-of-Network Out-of-Pocket Maximum (Includes Pharmacy Out-of-Pocket Maximum for Covered Prescription Drug Benefits)
Option C	$3,000 individual $6,000 family		$6,000 individual $12,000 family
Option D	$3,200 individual $6,400 family		$9,000 individual $18,000 family
	Enhanced Network Out-of-Pocket Maximum	**Standard Network Out-of-Pocket Maximum**	**Out-of-Network Out-of-Pocket Maximum**
Option E	$4,000 individual $8,000 family	$4,000 individual $8,000 family	$8,000 individual $16,000 family

COORDINATION OF BENEFITS

If you or your Eligible Dependent have medical coverage under another plan or plans, benefits under this Medical Plan and the other plan or plans will be subject to applicable Coordination of Benefits Procedures.

If you have elected Medical Coverage Option A, B, C or D, please refer to Appendix 2 for Anthem's Coordination of Benefits Procedures.

If you have elected Medical Coverage Option E, please refer to Appendix 3 for Peak Health's Coordination of Benefits Procedures.

OVERPAYMENT OF BENEFITS

To the extent that benefits under the Medical Plan are paid in error or are overpaid, the Medical Plan will have the right to recover such payment from you or, if applicable, to recover payment from the provider of services or to otherwise make appropriate offsets or adjustments to claims for Covered Medical Services and to take other action in accordance with applicable law.

SUBROGATION RIGHTS

If you or your Eligible Dependent receive medical care that is otherwise covered under the Medical Plan but is also payable by a liable third party, the Medical Plan may have certain subrogation rights. For this purpose, a "liable third party" is another person or entity that is legally responsible for payment with respect to medical care expenses. For example, an automobile insurance carrier may be legally responsible for payment of medical care expenses in connection with an injury suffered in an automobile accident.

To the extent that Covered Medical Services are paid or payable by a liable third party, the Medical Plan may be entitled to offset or recovery.

If you have elected Medical Coverage Option A, B, C or D, please refer to Appendix 2 for Anthem's Statement of Subrogation Rights.

If you have elected Medical Coverage Option E, please refer to Appendix 3 for Peak Health's Statement of

Subrogation Rights.

PREDETERMINATION OF BENEFITS AND CARE MANAGEMENT

If you have elected Medical Coverage Option A, B, C or D, please refer to Appendix 2 for Anthem's provisions on predetermination and precertification of Covered Medical Services.

If you have elected Medical Coverage Option E, please refer to Appendix 3 for Peak Health's provisions on care management and related provisions.

EXCLUDED SERVICES

If you have elected Medical Coverage Option A, B, C or D, please refer to Appendix 2 for Anthem's provisions on services excluded from coverage under the Medical Plan.

If you have elected Medical Coverage Option E, please refer to Appendix 3 for Peak Health's provisions on services excluded from coverage under the Medical Plan.

VI. WHEN MEDICAL COVERAGE ENDS

Medical coverage will end on the last day of the month in which the *earliest* of the following events occurs:

- You terminate employment with the Company or otherwise cease to meet the eligibility requirements;
- With respect to your Spouse or Children (including Incapacitated Children), they cease to meet the requirements of an Eligible Dependent;
- You begin active duty in the Armed Forces, National Guard, or Reserves of any state or country (except for temporary active duty of 31 days or less); or
- The Company terminates the Medical Plan.

Please note: Certain Eligible Employees covered under the Medical Plan who lose coverage due to retirement or death may be eligible for enrollment in the Hope Gas Retiree Health and Welfare Benefit Plan for retiree coverage and for spouse, surviving spouse and eligible dependent coverage. Please contact the Plan Administrator for further information.

VII. LEAVE OF ABSENCE

If your Medical coverage ends because you are no longer an active full-time employee due to a Company approved leave of absence, coverage may be reinstated effective upon returning to full-time employment status within 90 days after coverage had ended.

If your Medical coverage ends because you are on active duty in the Armed Forces, National Guard, or Reserves of any state or country (except for temporary active duty of 31 days or less), coverage may be reinstated effective upon returning to full-time employment status within 31 days after discharge from such active duty.

VIII. COBRA CONTINUATION COVERAGE

If your coverage or your Eligible Dependents' coverage under the Medical Plan ends due to a "**Qualifying Event**," you or your Eligible Dependents may elect to continue coverage as provided under the Consolidated Omnibus Budget Reconciliation Act ("**COBRA**").

Please refer to the Additional Information SPD for more information on Qualifying Events and the terms and conditions of COBRA coverage.

IX. FILING A CLAIM

If Covered Services are provided by an In-Network Provider, the provider will submit a claim directly to Anthem or to Peak Health, as applicable, and will notify you of any required copayment or balance, which you are responsible for paying to the provider.

If Covered Services are provided by an Out-of-Network Provider, the provider is not required to submit a claim directly to Anthem or to Peak Health, as applicable, and you are responsible for paying the amount due to the provider. You may then file a claim for reimbursement of the Covered Services, to the extent provided under the Medical Plan.

If you have chosen Medical Coverage Option A, B, C or D, your In-Network coverage is through the Anthem PPO network. To obtain a claim form for services from an Out-of-Network provider, go to www.anthem.com.

If you have chosen Medical Coverage Option E, your In-Network coverage is through the Peak Health PPO network. To obtain a claim form for services from an Out-of-Network provider, go to www.peakhealth.org.

For assistance with filing a claim with Anthem or Peak Health, contact Hope Gas Benefits:

Hope Gas, Inc. Benefits
781 Chestnut Ridge Road, Suite 100
Morgantown, WV 26505
(304) 566-2959
Samantha.j.baxter-nard@hopegas.com

X. CLAIMS PROCEDURES AND APPEALS

If you have elected Medical Coverage Option A, B, C or D, please refer to Appendix 2 for Anthem's Claims Procedures and Appeal Process.

If you have elected Medical Coverage Option E, please refer to Appendix 3 for Peak Health's Claims Procedures and Appeal Process.

XI. PLAN DOCUMENTS

The information in this Medical SPD has been prepared to describe the Medical Plan benefits under the Health and Welfare Benefit Plan that are available to you and your Eligible Dependents. If there is a conflict between this information and the official documents and contracts that govern the Medical Plan and the Health and Welfare Benefit Plan, including but not limited to the Anthem Benefit Booklet and the Peak Health Certificate of Coverage, as applicable, those official documents and contracts will govern.

XII. CHANGING OR TERMINATING THE MEDICAL PLAN

Please see the "Changing or Terminating the Plans" section of the Additional Information SPD for information on the Company's ability to change or terminate the Medical Plan.

XIII. REQUIREMENTS UNDER THE NO SURPRISES ACT

The Consolidated Appropriations Act of 2021 ("CAA") is a federal law that includes the No Surprises Act and certain provider transparency requirements.

In accordance with the CAA, if you receive Covered Medical Services due to a medical emergency from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Medical Services had been furnished by an In-Network Provider. However, Out-of-Network deductibles and coinsurance will apply to your claim if the treating Out-of-Network Provider determines

you are stable, meaning you have been provided necessary emergency care such that your condition will not materially

worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network costs, and the Out-of-Network Provider will also be able to charge you any difference between any applicable maximum benefit allowed and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Medical Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Medical Services from an Out-of-Network Provider at an In-Network Facility, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider.

However, if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges, claims will be paid at the Out-of-Network benefit level. This means you will be responsible for Out-of-Network costs for those services and the Out-of-Network Provider can also charge you any difference between any applicable maximum benefit allowed and the Out-of-Network Provider's billed charges.

The Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your Out-of-Pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered Medical Service had been furnished by an In-Network Provider. Ancillary Services are: (A) emergency services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

Out-of-Network Providers satisfy the Notice and Consent requirement (i) by obtaining your written consent not later than 72 hours prior to the delivery of services; or (ii) if Notice and Consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Out-of-Network Air Ambulance Services

If you receive Covered Medical Services from an Out-of-Network Air Ambulance Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Medical Service had been furnished by an In-Network Air Ambulance Provider.

How Cost-Shares Are Calculated

Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Medical Services from an Out-of-Network Provider at an In-Network Facility or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprises Act, you have the right to appeal that claim. If

your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization, as described in the Claims Procedures for the Medical Plan.

XIV. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE

Prior authorization is not required from the Plan Administrator, Anthem or Peak Health, as applicable, or from your PCP in order for you or your Eligible Dependent to obtain access to obstetrical or gynecological care from an In-Network Provider 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.

XV. STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

XVI. STATEMENT OF RIGHTS UNDER THE WOMEN'S CANCER RIGHTS ACT OF 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Medical Plan.

XVII. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance use disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health and substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance use disorder benefits offered under the plan. Also, the plan may not impose deductibles, copayments, coinsurance, and Out-of-Pocket expenses on mental health and substance use disorder benefits that are more restrictive than deductibles, copayment, coinsurance and Out-of-Pocket expenses applicable to other medical and surgical benefits under the plan. The Medical Plan is intended to comply with requirements under the Mental Health Parity and Addiction Equity Act. Medical Necessity criteria are available upon request by contacting the Plan Administrator.

XVIII. OTHER RIGHTS

The Company, for itself as Plan Administrator and on behalf of the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of deductible sources of income from a third party to the extent permitted under applicable federal or state laws and regulations. This right of recovery is enforceable even if the amount you receive from the third party is less than the

actual loss suffered by you, but the recovery will not exceed the benefits paid to you under the Plan. The Plan Administrator and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

APPENDIX A

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION A
ANTHEM BLUE CROSS AND BLUE SHIELD PPO ESSENTIAL PLAN

As of January 1, 2026, Covered Medical Services for Medical Coverage Option A - Anthem Blue Cross and Blue Shield PPO Essential Plan are as follows:

Visits with Virtual Care-Only Providers	Cost through Anthem Mobile App and Website
Primary Care and medical services for urgent/acute care	No charge after deductible met
Mental Health & Substance Use Disorder Services	No charge after deductible met
Specialist care	20% coinsurance after deductible met

	In-Network Provider	Out-Of-Network Provider
Doctor Visits (virtual and in-office)		
Primary Care Physician (PCP) and Mental Health and Substance Use Disorder Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic for routine care and treatment of common illnesses (usually found in major pharmacies or retail stores)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy (coverage is limited to 20 visits per benefit period)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs dispensed in-office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services Lab		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION A

ANTHEM BLUE CROSS AND BLUE SHIELD PPO ESSENTIAL PLAN (CONTINUED)

	In-Network Provider	Out-Of-Network Provider
X-Ray		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (MRI, PET, CAT Scan, etc.)		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees - Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and Other Services (including surgeon fees) - Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants (Cornea transplants treated the same as any other illness and subject to the medical benefits)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and Other Services (including surgeon fees)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care		
Home Health Care coverage is limited to 100 visits per benefit period. Limits are combined for all home health services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
Rehabilitation and Habilitation Services (Including physical, occupational and speech therapies)		
Coverage for occupational therapy, physical therapy and speech therapy is unlimited visits per benefit period.		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary Rehabilitation		
Coverage for office and outpatient hospital is unlimited visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac Rehabilitation		
Coverage for office and outpatient hospital is unlimited visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office and outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy		
Office and outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (Facility)		
Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is unlimited days combined per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice		
Inpatient hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment		
Durable Medical Equipment costs	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices		
Prosthetic Devices (coverage for wigs limited to one item after cancer treatment per benefit period)	20% coinsurance after deductible is met	50% coinsurance after deductible is met

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION A ANTHEM BLUE CROSS AND BLUE SHIELD PPO ESSENTIAL PLAN (CONTINUED)

	In-Network Provider	Out-Of-Network Provider
Covered Prescription Drug Benefits		
Network	Base Network	
Drug List	National Direct Plus (If a brand name drug is selected when a generic drug is available, additional cost sharing may apply)	
Drug Supply Limits	Retail Pharmacy: 30-day supply Retail 90 Pharmacy: 90-day supply Home Delivery Pharmacy: 90-day supply Specialty Pharmacy: 30-day supply	
Tier 1 – Typically Generic	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 2 – Typically Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 3 – Typically Non-Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 4 – Typically Specialty (brand and generic)	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)

APPENDIX B

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION B
ANTHEM BLUE CROSS AND BLUE SHIELD PPO ESSENTIAL PLAN WITH HSA

As of January 1, 2026, Covered Medical Services for Medical Coverage Option B - Anthem Blue Cross and Blue Shield PPO Essential Plan With HSA are as follows:

Visits with Virtual Care-Only Providers	Cost through Anthem Mobile App and Website
Primary Care and medical services for urgent/acute care	No charge after deductible met
Mental Health & Substance Use Disorder Services	No charge after deductible met
Specialist care	0% coinsurance after deductible met

	In-Network Provider	Out-Of-Network Provider
Doctor Visits (virtual and in-office)		
Primary Care Physician (PCP) and Mental Health and Substance Use Disorder Services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic for routine care and treatment of common illnesses (usually found in major pharmacies or retail stores)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy (coverage is limited to 20 visits per benefit period)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs dispensed in-office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services Lab		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met

ANTHEM BLUE CROSS AND BLUE SHIELD PPO ESSENTIAL PLAN WITH HSA

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
X-Ray		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (MRI, PET, CAT Scan, etc.)		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees - Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and Other Services (including surgeon fees) - Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants (Cornea transplants treated the same as any other illness and subject to the medical benefits)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and Other Services (including surgeon fees)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care		
Home Health Care coverage is limited to 100 visits per benefit period. Limits are combined for all home health services	0% coinsurance after deductible is met	50% coinsurance after deductible is met

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
Rehabilitation and Habilitation Services (Including physical, occupational and speech therapies)		
Coverage for occupational therapy, physical therapy and speech therapy is unlimited visits per benefit period.		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary Rehabilitation		
Coverage for office and outpatient hospital is unlimited visits per benefit period.	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac Rehabilitation		
Coverage for office and outpatient hospital is unlimited visits per benefit period.	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office and outpatient hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy		
Office and outpatient hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (Facility)		
Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is unlimited days combined per benefit period.	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice		
Inpatient hospice	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment		
Durable Medical Equipment costs	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices		
Prosthetic Devices (coverage for wigs limited to one item after cancer treatment per benefit period)	0% coinsurance after deductible is met	50% coinsurance after deductible is met

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION B
ANTHEM BLUE CROSS AND BLUE SHIELD PPO ESSENTIAL PLAN WITH HSA

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
Covered Prescription Drug Benefits		
Network	Base Network	
Drug List	National Direct Plus (If a brand name drug is selected when a generic drug is available, additional cost sharing may apply)	
Drug Supply Limits	Retail Pharmacy: 30-day supply Retail 90 Pharmacy: 90-day supply Home Delivery Pharmacy: 90-day supply Specialty Pharmacy: 30-day supply	
Tier 1 – Typically Generic	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 2 – Typically Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 3 – Typically Non-Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 4 – Typically Specialty (brand and generic)	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)

APPENDIX C

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION C
ANTHEM BLUE CROSS AND BLUE SHIELD PPO PREMIUM PLAN

As of January 1, 2026, Covered Medical Services for Medical Coverage Option C - Anthem Blue Cross and Blue Shield PPO Premium Plan are as follows:

Visits with Virtual Care-Only Providers	Cost through Anthem Mobile App and Website
Primary Care and medical services for urgent/acute care	No charge after deductible met
Mental Health & Substance Use Disorder Services	No charge after deductible met
Specialist care	20% coinsurance after deductible met

	In-Network Provider	Out-Of-Network Provider
Doctor Visits (virtual and in-office)		
Primary Care Physician (PCP) and Mental Health and Substance Use Disorder Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic for routine care and treatment of common illnesses (usually found in major pharmacies or retail stores)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy (coverage is limited to 20 visits per benefit period)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs dispensed in-office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services Lab		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

ANTHEM BLUE CROSS AND BLUE SHIELD PPO PREMIUM PLAN

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
X-Ray		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (MRI, PET, CAT Scan, etc.)		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees - Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and Other Services (including surgeon fees) - Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants (Cornea transplants treated the same as any other illness and subject to the medical benefits)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and Other Services (including surgeon fees)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care		
Home Health Care coverage is limited to 100 visits per benefit period. Limits are combined for all home health services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION C
ANTHEM BLUE CROSS AND BLUE SHIELD PPO PREMIUM PLAN

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
Rehabilitation and Habilitation Services (Including physical, occupational and speech therapies)		
Coverage for occupational therapy, physical therapy and speech therapy is unlimited visits per benefit period.		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary Rehabilitation		
Coverage for office and outpatient hospital is unlimited visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac Rehabilitation		
Coverage for office and outpatient hospital is unlimited visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office and outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy		
Office and outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (Facility)		
Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is unlimited days combined per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice		
Inpatient hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment		
Durable Medical Equipment costs	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices		
Prosthetic Devices (coverage for wigs limited to one item after cancer treatment per benefit period)	20% coinsurance after deductible is met	50% coinsurance after deductible is met

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION C
ANTHEM BLUE CROSS AND BLUE SHIELD PPO PREMIUM PLAN

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
Covered Prescription Drug Benefits		
Network	Base Network	
Drug List	National Direct Plus (If a brand name drug is selected when a generic drug is available, additional cost sharing may apply)	
Drug Supply Limits	Retail Pharmacy: 30-day supply Retail 90 Pharmacy: 90-day supply Home Delivery Pharmacy: 90-day supply Specialty Pharmacy: 30-day supply	
Tier 1 – Typically Generic	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 2 – Typically Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 3 – Typically Non-Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 4 – Typically Specialty (brand and generic)	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and not covered (home delivery)

APPENDIX D

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION D
ANTHEM BLUE CROSS AND BLUE SHIELD PPO PREMIUM PLAN WITH HSA

As of January 1, 2026, Covered Medical Services for Medical Coverage Option D - Anthem Blue Cross and Blue Shield PPO Premium Plan With HSA are as follows:

Visits with Virtual Care-Only Providers	Cost through Anthem Mobile App and Website
Primary Care and medical services for urgent/acute care	No charge after deductible met
Mental Health & Substance Use Disorder Services	No charge after deductible met
Specialist care	0% coinsurance after deductible met

	In-Network Provider	Out-Of-Network Provider
Doctor Visits (virtual and in-office)		
Primary Care Physician (PCP) and Mental Health and Substance Use Disorder Services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic for routine care and treatment of common illnesses (usually found in major pharmacies or retail stores)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy (coverage is limited to 20 visits per benefit period)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs dispensed in-office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services Lab		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met

ANTHEM BLUE CROSS AND BLUE SHIELD PPO PREMIUM PLAN

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
X-Ray		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (MRI, PET, CAT Scan, etc.)		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees - Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and Other Services (including surgeon fees) - Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants (Cornea transplants treated the same as any other illness and subject to the medical benefits)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and Other Services (including surgeon fees)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care		
Home Health Care coverage is limited to 100 visits per benefit period. Limits are combined for all home health services	0% coinsurance after deductible is met	50% coinsurance after deductible is met

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION D
ANTHEM BLUE CROSS AND BLUE SHIELD PPO PREMIUM PLAN

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
Rehabilitation and Habilitation Services (Including physical, occupational and speech therapies)		
Coverage for occupational therapy, physical therapy and speech therapy is unlimited visits per benefit period.		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary Rehabilitation		
Coverage for office and outpatient hospital is unlimited visits per benefit period.	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac Rehabilitation		
Coverage for office and outpatient hospital is unlimited visits per benefit period.	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office and outpatient hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy		
Office and outpatient hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (Facility)		
Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is unlimited days combined per benefit period.	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice		
Inpatient hospice	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment		
Durable Medical Equipment costs	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices		
Prosthetic Devices (coverage for wigs limited to one item after cancer treatment per benefit period)	0% coinsurance after deductible is met	50% coinsurance after deductible is met

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION D
ANTHEM BLUE CROSS AND BLUE SHIELD PPO PREMIUM PLAN

(CONTINUED)

	In-Network Provider	Out-Of-Network Provider
Covered Prescription Drug Benefits		
Network	Base Network	
Drug List	National Direct Plus (If a brand name drug is selected when a generic drug is available, additional cost sharing may apply)	
Drug Supply Limits	Retail Pharmacy: 30-day supply Retail 90 Pharmacy: 90-day supply Home Delivery Pharmacy: 90-day supply Specialty Pharmacy: 30-day supply	
Tier 1 – Typically Generic	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 2 – Typically Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 3 – Typically Non-Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail) and not covered (home delivery)
Tier 4 – Typically Specialty (brand and generic)	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail) and not covered (home delivery)

APPENDIX E

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION E
PEAK HEALTH PLAN

As of January 1, 2026, Covered Medical Services for Medical Coverage Option E - Peak Health Plan are as follows:

	Enhanced Network Provider	Standard Network Provider	Out-of-Network Provider
Co-Pays (*Co-pays do not apply to deductible or coinsurance limits*)			
Primary Care Office Visit/Consultation	$10 Co-Pay per visit	$30 Co-Pay per visit, 100% thereafter No deductible	50% coinsurance after deductible
Specialist Office Visit/Consultation (Includes Specialist Virtual Visits	$75 Co-Pay per visit	$150 Co-Pay per visit, 100% thereafter No deductible	50% coinsurance after deductible
Urgent Care	$100 Co-Pay per visit	$150 Co-Pay per visit, 100% thereafter No deductible	50% coinsurance after deductible
Emergency Care			
Emergency Accident Care/Emergency Medical Care Provided in the Emergency Room	$500 Co-Pay, 20% thereafter Co-Pay waived, if admitted to hospital	$500 Co-Pay, 20% thereafter No deductible Co-Pay waived, if admitted to hospital	$500 Co-Pay, 20% thereafter No deductible Co-Pay waived, if admitted to hospital
Emergency Ambulance (Ground, Water, Air)	100%	100% No deductible	100% No deductible
Non-Emergency Care			
Non-Emergency Medical Care Provided in the Emergency Room	$500 Co-Pay, 20% thereafter Co-Pay waived, if admitted to hospital	$500 Co-Pay, 20% thereafter No deductible Co-Pay waived, if admitted to hospital	$500 Co-Pay, 20% thereafter No deductible Co-Pay waived, if admitted to hospital
Non-Emergency Ground or Water Ambulance[3]	$500 Co-Pay, 100% thereafter Co-Pay waived, if admitted to hospital	$500 Co-Pay, 100% thereafter No deductible Co-Pay waived, if admitted to hospital	$500 Co-Pay, 100% thereafter No deductible Co-Pay waived, if admitted to hospital
Non-Emergency Air Ambulance	$500 Co-Pay, 100% thereafter Co-Pay waived, if admitted to hospital	$500 Co-Pay, 100% thereafter No deductible Co-Pay waived, if admitted to hospital	$500 Co-Pay, 100% thereafter No deductible Co-Pay waived, if admitted to hospital

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION E
PEAK HEALTH PLAN
(CONTINUED)

	Enhanced Network Provider	Standard Network Provider	Out-of-Network Provider
Preventive Care			
Routine Adult Preventive Services	100%	100% No deductible	50% coinsurance after deductible
Routine Pediatric Preventive Services	100%	100% No deductible	50% coinsurance after deductible
Behavioral Health			
Physician Office Visit - Mental Health Services, Substance Use Disorder	$30 Co-Pay per visit	$30 Co-Pay per visit, 100% thereafter No deductible	50% coinsurance after deductible
Outpatient Facility - Mental Health Services, Substance Use Disorder	$50 Co-Pay per visit	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Facility - Mental Health Services, Substance Use Disorder	100%	20% coinsurance after deductible	50% coinsurance after deductible
Physician			
Second Surgical Opinion Consultation (Outpatient)	100%	100% No deductible	50% coinsurance after deductible
Occupational Therapy (Rehabilitative and Habilitative) – Maximum 40 visits for adults per benefit period. Limitations combined for Physician/Outpatient Facility, all networks, and Rehabilitative/Habilitative.	$50 Co-Pay per visit	$100 Co-Pay per visit, 100% thereafter No deductible	50% coinsurance after deductible
Physical Therapy (Rehabilitative and Habilitative) – Maximum 40 visits for adults per benefit period. Limitations combined for Physician/Outpatient Facility, all networks, and Rehabilitative/Habilitative.	$50 Co-Pay per visit	$100 Co-Pay per visit, 100% thereafter No deductible	50% coinsurance after deductible
Spinal Manipulations (Rehabilitative and Habilitative) – Maximum 24 visits per benefit period. Limitations combined for Physician/Outpatient Facility, all networks, and Rehabilitative/Habilitative.	$30 Co-Pay per visit	$100 Co-Pay per visit, 100% thereafter No deductible	50% coinsurance after deductible
Speech Therapy (Rehabilitative and Habilitative) – Maximum 40 visits for adults per benefit period when necessary due to a medical condition. Limitations combined for Physician/Outpatient Facility, all networks, and Rehabilitative/Habilitative.	$30 Co-Pay per visit	$100 Co-Pay per visit,100% thereafter No deductible	50% coinsurance after deductible
Allergy Testing and Treatment	$40 Co-Pay per office/testing visit $5 Co-Pay per shot	20% coinsurance after deductible	50% coinsurance after deductible

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION E
PEAK HEALTH PLAN
(CONTINUED)

	Enhanced Network Provider	Standard Network Provider	Out-of-Network Provider
Physician (continued)			
All Other Covered Physician Services Diagnostic X-ray and Lab Testing; Dialysis, In-Hospital Medical Visit; Skilled Nursing Medical Visit; Surgery, Assistant to Surgery, and Anesthesia; Maternity Care (dependent daughters are covered); Newborn Care, including circumcision; Respiratory Therapy; Chemotherapy, Radiation Therapy, and Infusion Therapy; Services for diagnosis and treatment of Autism Spectrum Disorder.[6] Note: Other covered services will be paid according to the benefit category.	100%	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Facility			
Unlimited Days – Semi-Private Room and Board	100%	$500 Co-Pay per admission, subject to deductible and co-insurance	50% coinsurance after deductible
Ancillaries, Drugs, Therapy Services, X-Ray, and Lab	100%	20% coinsurance after deductible	50% coinsurance after deductible
General Nursing Care	100%	20% coinsurance after deductible	50% coinsurance after deductible
Surgical Services	100%	20% coinsurance after deductible	50% coinsurance after deductible
Birthing Center Care/Maternity Services – Dependent daughters are covered	100%	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Facility			
Pre-Admission Testing	100%	20% coinsurance after deductible	50% coinsurance after deductible
Basic Diagnostic, Basic Lab Services, and Testing	$10 Co-Pay per visit	20% coinsurance after deductible	50% coinsurance after deductible
Basic X-Ray	$40 Co-Pay per visit, (Bundle films + interpretation by radiologist)	20% coinsurance after deductible	50% coinsurance after deductible
Advanced Laboratory Testing and Imaging (including CT Scan, MRI, advanced laboratory tests including genetic testing and proprietary labs)	$500 Co-Pay per visit	$500 Co-Pay per visit, subject to deductible and co-insurance	50% coinsurance after deductible

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION E
PEAK HEALTH PLAN
(CONTINUED)

	Enhanced Network Provider	Standard Network Provider	Out-of-Network Provider
Outpatient Facility (continued)			
Surgery, Operating Room	100%	$500 Co-Pay per visit, subject to deductible and co-insurance	50% coinsurance after deductible
Occupational Therapy (Rehabilitative and Habilitative) – Maximum 40 visits for adults per benefit period. Limitations are combined for Physician/Outpatient Facility, all networks, and Rehabilitative/Habilitative.	100%	20% coinsurance after deductible	50% coinsurance after deductible
Physical Therapy (Rehabilitative and Habilitative) – Maximum 40 visits for adults per benefit period. Limitations are combined for Physician/Outpatient Facility, all networks, and Rehabilitative/Habilitative.	100%	20% coinsurance after deductible	50% coinsurance after deductible
Speech Therapy (Rehabilitative and Habilitative) – Maximum 40 visits for adults per benefit period when necessary due to a medical condition. Limitations are combined for Physician/Outpatient Facility, all networks, and Rehabilitative/Habilitative.	100%	20% coinsurance after deductible	50% coinsurance after deductible
Respiratory Therapy	$30 Co-Pay per visit	20% coinsurance after deductible	50% coinsurance after deductible
Cardiac Rehabilitation Therapy	$30 Co-Pay per visit	20% coinsurance after deductible	50% coinsurance after deductible
Dialysis (Non-hospital)	$50 Co-Pay per visit	20% coinsurance after deductible	50% coinsurance after deductible
Dialysis (Hospital-based)	$75 Co-Pay per visit	20% coinsurance after deductible	50% coinsurance after deductible
Chemotherapy	100%	20% coinsurance after deductible	50% coinsurance after deductible
Radiation Therapy	100%	20% coinsurance after deductible	50% coinsurance after deductible
Infusion Therapy	100%	20% coinsurance after deductible	50% coinsurance after deductible
Other Covered Services			
Private Duty Nursing – Maximum 35 visits per benefit period. Maximum combined for all networks	$50 Co-Pay per visit	20% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility – Maximum 120- day limit per benefit period. Maximum combined for all networks	100%	20% coinsurance after deductible	50% coinsurance after deductible

COVERED MEDICAL SERVICES – MEDICAL COVERAGE OPTION E
PEAK HEALTH PLAN

(CONTINUED)

	Enhanced Network Provider	Standard Network Provider	Out-of-Network Provider
Other Covered Services (continued)			
Durable Medical Equipment, Oxygen at Home	20% coinsurance	20% coinsurance after deductible	50% coinsurance after deductible
Orthotic Devices, Prosthetic Appliances	20% coinsurance	20% coinsurance after deductible	50% coinsurance after deductible
Home Healthcare – Maximum 100 visits per benefit period. Maximum combined for all networks.	$50 Co-Pay per visit	$50 Co-Pay per visit, 100% thereafter No deductible	50% coinsurance after deductible
Hospice Care – 12-month lifetime maximum. Maximum combined for all networks.	100%	100%, subject to Tier 1 deductible	50% coinsurance after deductible
Human Organ Transplant/Bone Marrow Procedure			
Human Organ Transplant – Includes transportation, meals, and lodging	100%	20% coinsurance after deductible	50% coinsurance after deductible
Bone Marrow Procedure – Includes transportation, meals, and lodging	100%	20% coinsurance after deductible	50% coinsurance after deductible
Pharmacy – The Navitus Health Solutions Network & Formulary			
Prescription Drug Deductible	None	None	None
<u>Prescription Drugs: 1 to 30 Day Supply</u> If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket	$15 Co-Pay – Preferred generics and some lower cost brand products $45 Co-Pay – Preferred brand products and non-preferred generics $90 Co-Pay – Non-preferred brand products and some high-cost non-preferred generics		
<u>Prescription Drugs: 31 to 90 Day Supply</u> If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket	$37.50 Co-Pay – Preferred generics and some lower cost brand products $112.50 Co-Pay – Preferred brand products and non-preferred generics $225 Co-Pay – Non-preferred brand products and some high-cost non-preferred generics		
<u>Specialty Drugs: Maximum 30-Day Supply</u> Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward	Member pays $350		

the Total Maximum Out-of-Pocket	

APPENDIX 1

MEDICAL COVERAGE COSTS

As of January 1, 2026, the costs for Medical coverage are as follows:

Medical Coverage Option A Anthem Blue Cross and Blue Shield PPO Essential Plan			
Coverage Level	**Employee Cost (Monthly)**	**Company Cost (Monthly)**	**Total Monthly Cost**
Employee only	$56.88	$849.84	$906.72
Employee and Spouse	$139.34	$2,021.24	$2,160.58
Employee and Eligible Dependent Children (including Incapacitated Children)	$173.44	$1,561.14	$1,734.58
Employee and Eligible Dependents (Spouse + Eligible Dependent Children)	$248.43	$2,719.15	$2,967.58

Medical Coverage Option B Anthem Blue Cross and Blue Shield HSA Essential Plan With HSA			
Coverage Level	**Employee Cost (Monthly)**	**Company Cost (Monthly)**	**Total Monthly Cost**
Employee only	$41.56	$661.91	$703.47
Employee and Spouse	$141.12	$1,584.49	$1,725.61
Employee and Eligible Dependent Children (including Incapacitated Children)	$167.57	$1,217.88	$1,385.45
Employee and Eligible Dependents (Spouse + Eligible Dependent Children)	$226.61	$2,174.31	$2,400.92

Medical Coverage Option C Anthem Blue Cross and Blue Shield PPO Premium Plan			
Coverage Level	**Employee Cost (Monthly)**	**Company Cost (Monthly)**	**Total Monthly Cost**
Employee only	$136.00	$868.37	$1,004.37
Employee and Spouse	$285.52	$2,055.49	$2,341.01
Employee and Eligible Dependent Children (including Incapacitated Children)	$348.27	$1,534.70	$1,882.97
Employee and Eligible Dependents (Spouse + Eligible Dependent Children)	$489.65	$2,799.34	$3,288.99

Medical Coverage Option D Anthem Blue Cross and Blue Shield HSA Premium Plan With HSA			
Coverage Level	**Employee Cost (Monthly)**	**Company Cost (Monthly)**	**Total Monthly Cost**
Employee only	$47.49	$822.50	$869.99
Employee and Spouse	$159.88	$1,989.81	$2,149.69
Employee and Eligible Dependent Children (including Incapacitated Children)	$189.61	$1,549.33	$1,738.94
Employee and Eligible Dependents (Spouse + Eligible Dependent Children)	$256.51	$2,677.32	$2,933.83

Medical Coverage Option E Peak Health Plan			
Coverage Level	**Employee Cost (Monthly)**	**Company Cost (Monthly)**	**Total Monthly Cost**
Employee only	$136.00	$868.37	$1,004.37
Employee and Spouse	$285.52	$2,055.49	$2,341.01
Employee and Eligible Dependent Children (including Incapacitated Children)	$348.27	$1,534.70	$1,882.97
Employee and Eligible Dependents (Spouse + Eligible Dependent Children)	$489.65	$2,799.34	$3,288.99

APPENDIX 2

ADDITIONAL MEDICAL PLAN PROVISIONS - MEDICAL COVERAGE OPTIONS A, B, C AND D

I. PREDETERMINATION AND PRECERTIFICATION OF BENEFITS
II. EXCLUDED SERVICES
III. COORDINATION OF BENEFITS
IV. SUBROGATION
V. CLAIMS PROCEDURES

The following provisions are taken from the Anthem Benefit Booklet, which constitutes and forms a part of the Medical Plan. Please refer to the Anthem Benefit Booklet for further information.

I. PREDETERMINATION AND PRECERTIFICATION OF BENEFITS

The Medical Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in the Anthem Benefit Anthem Benefit Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

REVIEWING WHERE SERVICES ARE PROVIDED

A service must be Medically Necessary to be a Covered Medical Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens, the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician’s office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Medical Plan, on behalf of the Company, may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. “Clinically equivalent” means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Anthem Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if it is decided your services are Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be a Covered Medical Service under the Medical Plan;

4. The service cannot be subject to an Exclusion under the Medical Plan; and
5. You must not have exceeded any applicable limits under the Medical Plan.

TYPES OF REVIEW

- **Pre-service Review –** A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

  - **Precertification –** A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. Please contact Anthem at the Member Services telephone number on the back of your Identification Card to determine if a Prior Authorization or a Precertification is required. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in the Anthem Benefit Booklet. For admissions following Emergency Care, you, your authorized representative or Doctor must tell Anthem of the admission as soon as possible. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

- **Continued Stay / Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

  Both Pre-Service and Continued Stay / Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage determination that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with Anthem to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Please contact Anthem at the Member Services telephone number on the back of your Identification Card to determine if a Prior Authorization or a Precertification is required.

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	The Provider must get Precertification when required

Provider Network Status	Responsibility to Get Precertification	Comments
Out-of-Network / Non-Participating	Member	Member must get Precertification when required. (Call Member Services.) Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is
BlueCard Provider	Member (Except for Inpatient Admissions	Member must get Precertification when required. (Call Member Services.) Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell us of the admission as soon as possible.		

How Decisions are Made

Anthem uses clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section “Prescription Drugs Administered by a Medical Provider” in the Anthem Benefit Booklet. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. Anthem reserves the right, on behalf of the Company, to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Anthem Identification Card.

If you are not satisfied with the decision under this section of your benefits, please refer to the section on Appeals in this Appendix or in the Anthem Benefit Booklet.

Decision and Notice Requirements

Anthem will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on federal laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Anthem Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification

Urgent Pre-service Review	Requests submitted via phone or fax: 72 hours from receipt of request Requests submitted electronically: 48 hours from receipt of request
Type of Review	**Timeframe Requirement for Decision and Notification**
Non-Urgent Pre-service Review	Requests submitted via phone or fax: 15 calendar days Requests submitted electronically: 10 calendar days
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of request
Non-urgent Continued Stay/Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of request.
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed for Anthem to make a decision, it will notify the requesting Provider of the specific information needed to finish the review. If Anthem does not get the specific information needed by the required timeframe, it will make a decision based upon the information it has.

Anthem will notify you and your Provider of the decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

From time to time certain medical management processes (including utilization management, case management, and disease management) may be waived, enhanced, changed or ended. An alternate benefit may be offered if in the Plan's discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may be selected to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

Just because the Plan exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that this will occur in the future, or will do so in the future for any other Provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Member Services number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review

of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

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

Anthem's Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.. If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

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

II. EXCLUDED SERVICES

In this section you will find a review of items that are not covered by the Medical Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by the Medical Plan.

The Medical Plan does not provide benefits under Medical Coverage Option A, B, C or D for procedures, equipment, services, supplies or charges for or in connection with the following:

1) **Abortion.** This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother, as a result of incest or rape, or as recommended by a Doctor.

2) **Acts of War, Disasters, or Nuclear Accidents.** In the event of a major disaster, epidemic, war, or other event beyond our control, Anthem will make a good faith effort to give you Covered Services. Anthem and the Medical Plan will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

3) **Administrative Charges.**

a) Charges to complete claim forms,
b) Charges to get medical records or reports,

c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

4) **Aids for Non-verbal Communication.** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by the Medical Plan.

5) **Alternative / Complementary Medicine.** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

a) Acupuncture,
b) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
c) Holistic medicine,
d) Homeopathic medicine,
e) Hypnosis,
f) Aroma therapy,
g) Massage and massage therapy,
h) Reiki therapy,
i) Herbal, vitamin or dietary products or therapies,
j) Naturopathy,
k) Thermography,
l) Orthomolecular therapy,
m) Contact reflex analysis,
n) Bioenergetic synchronization technique (BEST),
o) Iridology-study of the iris,
p) Auditory integration therapy (AIT),
q) Colonic irrigation,
r) Magnetic innervation therapy,
s) Electromagnetic therapy,

6) **Applied Behavior Analysis.** Charges for services related to Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis) except as described under Autism Services in the "What's Covered" section in the Anthem Benefit Booklet.

7) **Autopsies.** Autopsies and post-mortem testing.

8) **Before Effective Date or After Termination Date.** Charges for care you get before your Effective Date or after your coverage ends, except as specifically provided written in the Medical Plan.

9) **Certain Providers.** Service you get from Providers that are not licensed by law to provide Covered Services as defined in the Anthem Benefit Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

10) **Charges Not Supported by Medical Records.** Charges for services not described in your medical records.

11) **Charges Over the Maximum Allowed Amount.** Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the Anthem Benefit Booklet.

12) **Clinical Trial Non-Covered Services.** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under the Medical Plan for non-Investigational treatments.

13) **Clinically-Equivalent Alternatives.** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most covered individuals, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit www.anthem.com**.**

If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with Anthem. The Medical Plan will cover the other Prescription Drug only if Anthem agrees that it is Medically Necessary and appropriate over the clinically equivalent Drug. Anthem will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary**.**

14) **Complications of/or Services Related to Non-Covered Services.** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by the Medical Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to services that are Medically Necessary Covered Services under the Medical Plan.

15) **Compound Ingredients.** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

16) **Cosmetic Services.** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.

17) **Court Ordered Testing.** Court ordered testing or care unless Medically Necessary. This Exclusion does not apply to Covered Services that have not been exhausted and are not paid for by another source.

18) **Cryopreservation,** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

19) **Custodial Care.** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

20) **Delivery Charges.** Charges for delivery of Prescription Drugs.

21) **Dental Devices for Snoring.** Oral appliances for snoring.

22) **Dental Treatment.**

Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth;

- Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded. This Exclusion does not apply to services that the Plan must cover by law.

23) **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

24) **Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Medical Plan or by Anthem.

25) **Drugs Over the Quantity Prescribed or Refills After One Year.** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

26) **Drugs That Do Not Need a Prescription.** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section in the Anthem Benefit Booklet.

27) **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications.** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.

28) **Educational Services.** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

29) **Emergency Room Services for non-Emergency Care.** Services provided in an emergency room for conditions that do not meet the Medical Plan's definition of Emergency. This includes, but is not limited to, suture removal routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, upper respiratory illness, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, dental caries/cavity. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.

30) **Experimental or Investigational Services.** Services or supplies that Anthem finds are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it a Covered Service if Anthem concludes it is Experimental / Investigational. Details on the criteria Anthem uses to determine if a Service is Experimental or Investigational is outlined below.

31) **Eyeglasses and Contact Lenses.** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in the Anthem Benefit Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

32) **Exercises.** Orthoptics and vision therapy.

33) **Eye Surgery.** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

34) **Family Members.** Services prescribed, ordered, referred by or given by a member of your

immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

35) **Foot Care.** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

a) Cleaning and soaking the feet.

b) Applying skin creams to care for skin tone.

c) Other services that are given when there is not an illness, injury or symptom involving the foot.

36) **Foot Orthotics.** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

37) **Foot Surgery.** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

38) **Fraud, Waste, Abuse, and Other Inappropriate Billing.** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

39) **Free Care.** Services you would not have to pay for if you didn't have coverage under the Medical Plan. This includes, but is not limited to government programs, services you get from Workers Compensation, and services from free clinics.

If the Company is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

40) **Growth Hormone Treatment.** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

41) **Health Club Memberships and Fitness Services.** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

42) **Home Health Care.**

a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

b) Food, housing, homemaker services and home delivered meals.

43) **Hospital Services Billed Separately.** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

44) **Hyperhidrosis Treatment.** Medical and surgical treatment of excessive sweating (hyperhidrosis).

45) **Infertility Treatment.** Testing or treatment related to infertility.

46) **Lost or Stolen Drugs.** Refills of lost or stolen Drugs.

47) **Maintenance Therapy.** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to

"Habilitative Services" as described in the "What's Covered" section in the Anthem Benefit Booklet.

48) **Medical Equipment, Devices and Supplies.**

a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft. Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

b) Non-Medically Necessary enhancements to standard equipment and devices.

c) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.

d) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section in the Anthem Benefit Booklet.

e) Continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.

49) **Medicare.** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions" in the Anthem Benefit Booklet. If you do not enroll in Medicare Part B when you are eligible, you may have large Out-of-Pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties .

50) **Missed or Cancelled Appointments.** Charges for missed or cancelled appointments.

51) **Non-approved Drugs.** Drugs not approved by the FDA.

52) **Non-Approved Facility.** Services from a Provider that does not meet the definition of Facility.

53) **Non-Approved Residential Treatment Center.** Services from a facility, residential treatment center, or residential treatment facility that do not fall within the definition of Facility or Residential Treatment Center in the Anthem Benefit Booklet.

54) **Non-Medically Necessary Services.** Services Anthem concludes are not Medically Necessary. This includes services that do not meet Anthem's medical policy, clinical coverage, or benefit policy guidelines.

55) **Nutritional or Dietary Supplements.** Nutritional and/or dietary supplements, except as described in the Anthem Benefit Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

56) **Off label use.** Only when approved by Anthem or the PBM, or when the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature that meets certain criteria. Medical literature may be accepted only if all of the following apply: (1) Two articles from major peer-reviewed professional medical journals have recognized the drug's safety and effectiveness for treatment of the indication for which it has been prescribed; (2) No article from a major peer-reviewed professional medical journal has concluded that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; (3) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical

journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer-reviewed medical literature.

57) **Oral Surgery.** Extraction of teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in the Anthem Benefit Booklet.

58) **Personal Care, Convenience and Mobile/Wearable Devices.**

a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads), Home workout or therapy equipment, including treadmills and home gyms,

c) Pools, whirlpools, spas, or hydrotherapy equipment.

d) Hypoallergenic pillows, mattresses, or waterbeds,

e) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

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

59) **Private Duty Nursing.** Private Duty Nursing Services given in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are a Covered Service only when given as part of the “Home Health Care Services” benefit described in the Anthem Benefit Booklet.

60) **Prosthetics.** Prosthetics for sports or cosmetic purposes.

61) **Residential accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center**.** This Exclusion includes procedures, equipment, services, supplies or charges for the following:

a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a covered individual’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

b) 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.

c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outwardbound programs, even if psychotherapy is included.

62) **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the “Preventive Care” Benefit” benefit described in the Anthem Benefit Booklet.

63) **Sanctioned or Excluded Providers.** Any service, Drug, Drug regimen, treatment, or supply, furnished , ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This Exclusion does not apply to Emergency Care.

64) **Sexual Dysfunction.** Services or supplies for male or female sexual problems.

65) **Stand-By Charges.** Stand-by charges of a Doctor or other Provider.

66) **Sterilization.** Services to reverse an elective sterilization.

67) **Surrogate Mother Services.** Services or supplies for a person not covered under the Medical Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

68) **Temporomandibular Joint Treatment.** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

69) **Travel Costs.** Mileage, lodging, meals, and other Member-related travel costs except as described in the Medical Plan or in the Anthem Benefit Booklet.

70) **Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

71) **Vision Services.** Vision services not described as Covered Services in the Anthem Benefit Booklet.

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

73) **Weight Loss Programs.** Programs, whether or not under medical supervision, unless listed as covered in the Anthem Benefit Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This Exclusion does not apply to weight management programs required under federal law as part of the “Preventive Care” benefit described in the Anthem Benefit Booklet.

74) **Wilderness or other outdoor camps and/or programs.**

WHAT’S NOT COVERED UNDER YOUR PRESCRIPTION DRUG RETAIL OR HOME DELIVERY (MAIL ORDER) PHARMACY BENEFIT

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges.** Charges for the administration of any Drug except for covered immunizations as approved by Anthem or the PBM.

2. **Charges Not Supported by Medical Records.** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

3. **Clinical Trial Non-Covered Services.** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under the Medical Plan for non-Investigational treatments.

4. **Clinically-Equivalent Alternatives.** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit www.anthem.com.

5. **Compound Ingredients.** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an

FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

6. **Contrary to Approved Medical and Professional Standards.** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

7. **Delivery Charges.** Charges for delivery of Prescription Drugs.

8. **Drugs Given at the Provider's Office / Facility.** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the section "Prescription Drugs Administered by a Medical Provider", or Drugs covered under the "Medical and Surgical Supplies" benefit in the Anthem Benefit Booklet – they are Covered Services.

9. **Drugs Not on the Anthem Prescription Drug List (a formulary).** You can get a copy of the list by calling Anthem or visiting www.anthem.com.

If you or your Doctor believes you need a certain Prescription Drug not on the list, please have your Doctor or pharmacist get in touch with Anthem. The Medical Plan will cover the other Prescription Drug only if Anthem, on behalf of the Company, agrees that it is Medically Necessary and appropriate over the Drugs on the List. Anthem will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

10. **Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Medical Plan.

11. **Drugs Over the Quantity Prescribed or Refills After One Year.** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications.** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by the Medical Plan.

13. **Drugs That Do Not Need a Prescription.** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section in the Anthem Benefit Booklet.

14. **Family Members.** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

15. **Fraud, Waste, Abuse, and Other Inappropriate Billing.** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

16. **Gene Therapy.** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit described in the Anthem Benefit Booklet, benefits may be available under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit in the Anthem Benefit Booklet. Please see that section for details.

17. **Growth Hormone Treatment.** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

18. **Hyperhidrosis Treatment.** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

19. **Infertility Drugs.** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)

20. **Items Covered as Durable Medical Equipment (DME).** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit described in the Anthem Benefit Booklet may be covered under the "Durable Medical Equipment (DME), Medical Devices and Supplies" benefit. Please see that section for details.

21. **Items Covered Under the "Allergy Services" Benefit.** Allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit, these items may be covered under the "Allergy Services" benefit. Please see that section in the Anthem Benefit Booklet for details.

22. **Lost or Stolen Drugs.** Refills of lost or stolen Drugs.

23. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider.** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.

24. **Non-approved Drugs.** Drugs not approved by the FDA.

25. **Non-Medically Necessary Services.** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

26. **Nutritional or Dietary Supplements.** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

27. **Onychomycosis Drugs.** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.

28. **Over-the-Counter Items.** Drugs, devices and products, or Prescription Drugs with over-the-counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over-the-counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Drugs when any version or strength becomes available over-the-counter.

This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription when Members have been certified as deaf or hearing impaired by a Physician or licensed audiologist.

29. **Sanctioned or Excluded Providers.** Any Drug, Drug regimen, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.

30. **Sexual Dysfunction Drugs.** Drugs to treat sexual or erectile problems.

31. **Syringes.** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

32. **Weight Loss Drugs.** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL 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 problem which is determined to be Experimental or Investigational is not covered by the Medical Plan.

The Medical Plan will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if determined that one of more of the criteria listed below apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental or Investigational based on the criteria above may still be deemed Experimental or Investigational. In deciding whether a service is Experimental or Investigational, the Plan will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

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

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s)used by 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 Medical Plan has the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

III. COORDINATION OF BENEFITS

The following Coordination of Benefits provisions apply when a person is covered under the Medical Plan and has health care coverage under another Health Coverage Plan (as defined below).

The order of benefit determination rules govern the order in which each plan providing health care covered (referred to in these Coordination of benefits provisions as a "**Health Coverage Plan**") will pay a claim for benefits. The Health Coverage Plan that pays first is called the "**Primary Plan**." The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Medical Plan may cover some expenses. The Health Coverage Plan that pays after the Primary Plan is the "**Secondary Plan**."

The Secondary Plan may reduce the benefits it pays so that payments from all Medical Plans do not exceed 100% of the total Allowable Expense.

DEFINITIONS

- **Health Coverage Plan**. A Health Coverage Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no Coordination of Benefits those separate contracts.

    1. A Health Coverage Plan includes: group and non-group insurance contracts, health insuring corporation ("**HIC**") contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

    2. Health Coverage Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Ohio's Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Health Coverage Plan. If a Health Coverage Plan has two parts and Coordination of Benefits rules apply only to one of the two, each of the parts is treated as a separate Health Coverage Plan.

- "**This plan**" means, in a Coordination of Benefits provision, the part of the contract providing the health care benefits to which the Coordination of Benefits provision applies and which may be reduced

because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one Coordination of Benefits provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another Coordination of Benefits provision to coordinate other benefits.

- **Order of Benefit Determination**. The order of benefit determination rules determine whether the Medical Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Health Coverage Plan. When the Medical Plan is primary, it determines payment for its benefits first before those of any other Health Coverage Plan without considering any other Health Coverage Plan's benefits. When the Medical Plan is secondary, it determines its benefits after those of another Health Coverage Plan and may reduce the benefits it pays so that all Health Coverage Plan benefits do not exceed 100% of the total Allowable Expense.

- "**Allowable Expense**" is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Health Coverage Plan covering the person. When a Health Coverage Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Health Coverage Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Health Coverage Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Health Coverage Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Health Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Health Coverage Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Health Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Health Coverage Plans.

   However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Health Coverage Plan's provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

6. If (i) the Primary Plan is a high-deductible Health Coverage Plan, (ii) all Health Coverage Plans covering the person are high-deductible plans, and (iii) the covered person contributes to a health savings account (HSA), then the amount that is subject to the Primary Plan's deductible is not an Allowable Expense.

- A "**Closed Panel Plan**" is a Health Coverage Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers which have contracted with or are employed by the Health Coverage Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

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

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

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Health Coverage Plans, the rules for determining the order of

benefit payments are as follows:

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

B. (1) Except as provided in Paragraph (2), a Health Coverage Plan that does not contain a Coordination of Benefits provision that is consistent with these Coordination of Benefits provisions is always the Primary Plan, unless the provisions of both Health Coverage Plans state that the complying plan is the Primary Plan.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Health Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Health Coverage Plan may consider the benefits paid or provided by another Health Coverage Plan in calculating payment of its benefits only when it is the Secondary Plan to that other Health Coverage Plan.

D. Each Health Coverage Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Health Coverage Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Health Coverage Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Coverage Plan covering the person as a dependent, and primary to the Health Coverage Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Health Coverage Plans is reversed so that the Health Coverage Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Health Coverage Plan is the Primary Plan.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Health Coverage Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Health Coverage Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
- If both parents have the same birthday, the Health Coverage Plan that has covered the parent the longest is the Primary Plan.
- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), the Medical Plan will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Health Coverage Plan of that parent has actual knowledge of those terms, that Health Coverage Plan is the Primary

Plan. This rule applies to plan years commencing after the Health Coverage Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Health Coverage Plan covering the Custodial Parent;
- The Health Coverage Plan covering the spouse of the Custodial Parent;
- The Health Coverage Plan covering the non-Custodial Parent; and then
- The Health Coverage Plan covering the spouse of the non-Custodial Parent.

(c) For a dependent child covered under more than one Health Coverage Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Health Coverage Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Health Coverage Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Health Coverage Plan does not have this rule, and as a result, the Health Coverage Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Health Coverage Plan, the Health Coverage Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Health Coverage Plan does not have this rule, and as a result, the Health Coverage Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Health Coverage Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Health Coverage Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Health Coverage Plans. In addition, the medical Plan will not pay more than it would have paid had it been the Primary Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these Coordination of Benefit rules and to determine benefits payable under the Medical Plan and other Health Coverage Plans. The Medical Plan may get the facts it needs from them or give them to other organizations or persons for the

purpose of applying these rules and determining benefits payable under Medical Plan and other Health Coverage Plans covering the person claiming benefits. The Medical Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under the Medical Plan must give the Plan Administrator, in writing, any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by the Medical Plan is more than should have paid under this Coordination of Benefits provision, the Medical Plan may recover the excess from one or more of the persons the Medical Plan paid or for whom the Medical Plan had paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If you believe that the Medical Plan has not paid a claim properly, you should first attempt to resolve the problem by contacting the Plan Administrator in writing. Follow the steps described in the "Your Right To Appeal" section in this Appendix and in the Anthem Benefit Booklet.

IV. SUBROGATION AND REIMBURSEMENT

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

DEFINITIONS

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

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

be subject to these provisions.

SUBROGATION

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

REIMBURSEMENT

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Medical Plan first from such payment for all amounts the Medical Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your Recovery. If you obtain a Recovery and the Medical Plan has not been repaid for the benefits the Medical Plan paid on your behalf, the Medical Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf. You must promptly reimburse the Medical Plan from any Recovery to the extent of benefits the Medical Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

Secondary to Other COVERAGE

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

ASSIGNMENT

In order to secure the Medical Plan's rights under these Subrogation and Reimbursement Provisions, you agree to assign to the Medical Plan any benefits or claims or rights of Recovery you have under any automobile policy or other coverage, to the full extent of the Medical Plan's subrogation and reimbursement claims. This assignment allows the Medical Plan to pursue any claim you may have regardless of whether you choose to pursue the claim.

APPLICABILITY TO ALL SETTLEMENTS AND JUDGMENTS

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

CONSTRUCTIVE TRUST

By accepting benefits from the Medical Plan, you agree that if you receive any payment as a result of an

injury, illness or condition, you will serve as a constructive trustee over those funds. You and your legal representative must hold in trust for the Medical Plan the full amount of the Recovery to be paid to the Medical Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Medical Plan. Any Recovery you obtain must not be dissipated or disbursed until such time as the Medical Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

LIEN RIGHTS

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

FIRST-PRIORITY CLAIM

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

COOPERATION

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

- You must promptly notify the Medical Plan in writing by contacting the Plan Administrator of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Medical Plan.
- You must notify the Medical Plan in writing by contacting the Plan Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition.
- You must cooperate with the Medical Plan in the investigation, settlement and protection of the Medical Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Medical Plan to exercise its subrogation or reimbursement rights, the Medical Plan shall be entitled to deduct the amount the Medical Plan paid from any future benefits under the Medical Plan.
- You and your agents shall provide all information requested by the Medical Plan, the Plan Administrator, the Claims Administrator or its representative including, but not limited to, completing and submitting

any applications or other forms or statements as the Medical Plan may reasonably request and all documents related to or filed in personal injury litigation.

- You recognize that to the extent that the Medical Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Medical Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or Recovery that attempts to reduce or exclude the full cost of all benefits provided by the Medical Plan.
- You must send the Medical 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 Medical Plan in writing by contacting the Plan Administrator if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the Medical Plan in writing by contacting the Plan Administrator if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that you or your legal representative fails to do whatever is necessary to enable the Medical Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Medical Plan shall be entitled to deduct the amount the Medical Plan paid from any future benefits under the Medical Plan.

If you fail to repay the Medical Plan, the Medical Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Medical Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Medical Plan if the amount the Medical Plan paid on your behalf is not repaid or otherwise recovered by the Medical Plan; or you fail to cooperate.

In the event you fail to disclose the amount of your settlement to the Medical Plan, the Medical Plan shall be entitled to deduct the amount of the Medical Plan's lien from any future benefit under the Medical Plan.

The Medical Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Medical Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Medical 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 Medical Plan will not have any obligation to pay the Provider or reimburse you.

You acknowledge the Medical Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of Recovery. The Medical Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys. You acknowledge that the Medical Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("**HIPAA**"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising these Subrogation and Reimbursement provisions.

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

DISCRETION

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

V. CLAIMS PROCEDURES AND APPEAL PROCEDURES

The Company wants your experience with respect to the Medical Plan to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about the Medical Plan or a

service you have received. In those cases, please contact Anthem by calling the number on the back of your Anthem Identification Card. Anthem and the Plan Administrator will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file an appeal, which is defined as follows:

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

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

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure the Medical Plan 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 Medical Plan's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific provision(s) of the Medical Plan on which the determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Medical 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 within one year of the grievance or appeals decision if you submit a grievance or appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination 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; and
- Information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- The Medical Plan's notice will also include a description of the applicable urgent/concurrent review process; and
- The Medical Plan may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

APPEALS

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

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

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

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

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

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568.

You must include Your Member Identification Number when submitting an appeal.

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

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Medical 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 Medical Plan 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, we will provide you, free of charge, with

the rationale.

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

How Your Appeal will be Decided

When the Medical Plan considers your appeal, it will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination. If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Medical Plan will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Medical Plan will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the Medical Plan will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

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

If, after the Medical Plan’s determination that you are appealing, it will consider, rely on or generate any new or additional evidence in connection with your claim, and will provide you with that new or additional evidence, free of charge. The Medical Plan will not base an appeal(s) decision(s) on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Medical Plan fails to follow the appeal procedures outlined under this section the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

Voluntary Second Level Appeals

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

External Review

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

within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Medical Plan 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 our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between us and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact us at the number shown on your Identification Card and provide at least the following information:

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

All other requests for External Review should be submitted in writing unless the Medical Plan determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

You must include Your Member Identification Number when submitting an appeal.

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

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Medical Plan's final decision on the claim or other request for benefits. If the Medical Plan decides a grievance or appeal is untimely, the Medical Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Medical Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Medical Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your grievance or appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

The Company and Anthem reserve the right to modify the Medical Plan's policies, procedures and timeframes in this section upon further clarification from Department of Health and Human

Services and Department of Labor.

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

APPENDIX 3

ADDITIONAL MEDICAL PLAN PROVISIONS - MEDICAL COVERAGE OPTION E

I. MEDICAL MANAGEMENT
II. BENEFIT EXCLUSIONS
III. COORDINATION OF BENEFITS
IV. SUBROGATION
V. CLAIMS PROCEDURES

The following provisions are taken from the Peak Health Certificate of Coverage, which constitutes and forms a part of the Medical Plan. Please refer to the Peak Health Certificate of Coverage for further information.

I. MEDICAL MANAGEMENT

The mission of Peak Health Medical Management is to provide holistic care experience for covered individuals, their caregivers, and their Providers. Medical management at Peak Health is comprised of the core services areas listed below:

- Care Management
- Quality
- Pharmacy
- Utilization Management

CARE MANAGEMENT PROGRAMS

Peak Health is proud to offer a robust care management program. The program has four tracks: routine care management, behavioral healthcare management, complex care management, and discharge and transition of care planning. Peak Health's care managers use health risk assessments paired with caregiver and Provider referrals to ensure that each Member maximizes their health potential.

Coordination and Transition of Care

Peak Health strives to provide excellent coordination and transitions of care. Peak Health's transition coordinators work with providers and covered individuals to ensure a smooth transition occurs and all needs are addressed.

Member referrals for Care Management

Covered individuals may request care management services by phone at 1-833-5-MYPEAK (1-833-569-7325), Monday through Friday, 8:00am to 5:00pm ET, excluding holidays. Services can also be requested by mail or electronically via Peak Health's member portal.

QUALITY

Covered Individual Experience

Peak Health subscribes to a member-centric healthcare approach. Peak Health commits to ensuring that covered individual experience and Provider experience data are incorporated into Peak Health's yearly work plan for care management. Peak Health encourages and welcomes ongoing feedback from covered individuals, their caregivers, and our Providers.

Quality Metric Monitoring Programs and Performance Improvement:

To provide high-quality care for covered individuals, Peak Health maintains an ongoing performance improvement plan around the metrics that matter. A brief list of the key metrics includes cost and utilization data, readmissions, preventive care, covered individual and Provider experience data, and program specific goals.

PHARMACY

Peak Health provides medical pharmacy benefit for each covered individuals. Drugs covered under the medical pharmacy benefit are typically administered and obtained at the healthcare provider's office. The Peak Health utilization management team provides expertise and timely management of pharmacologic utilization review. Pharmacists at Peak Health act as key pharmacy-strategists to maintain policies and procedures and to develop future opportunities for innovation and ongoing advancement. A strict cadence is maintained for review of pharmacologics that require prior authorization. The requirements for medical necessity are approved by the Pharmacy and Therapeutics Committee as well as our Clinical Governance and Quality Committee.

All drugs covered under the prescription drug benefit will be managed through Navitus Health Solutions. Please contact Navitus Health Solutions for coverage details. Contact information can be found on the back of your Peak Health Identification Card.

UTILIZATION MANAGEMENT

Utilization management is the system that Peak Health uses to evaluate services for Medical Necessity and Appropriateness and includes processes such as Prior Authorization, concurrent review, and retrospective review. For example, Peak Health must approve some services before they can be provided. This requirement is called Prior Authorization. You may have to pay for a service that requires a Prior Authorization if it is given before this authorization is obtained. Your provider can request Prior Authorization for services on your behalf.

Peak Health will approve all services that meet Prior Authorization criteria for medical necessity. Peak Health doctors, pharmacists, and nurses will review these authorization requests.

An updated prior authorization list and medical policies can be found **peakhealth.org** under the Provider Policy section.

If you have questions about which services require Prior Authorization, you can contact Member Service by calling 1-833-5-MYPEAK (1-833-569-7325) Monday through Friday, 8:00am to 5:00pm ET, excluding holidays. Services can also be requested electronically via the member portal.

II. STANDARD BENEFIT EXCLUSIONS

The following benefit exclusions are standard to Peak Group Health Plan contracts; for any exceptions to these exclusions, please contact Member Service at Peak Health for assistance:

- For services not required for health reasons including employment, insurance, or government licenses, and court-ordered, forensic, or custodial evaluations, unless otherwise covered under the Medical Plan or required by law.
- Services not prescribed by or performed by or under the direction of a Physician or another Provider.
- Not performed within the scope of the Provider's license.
- Experimental or Investigational.
- Not Medically Necessary and Appropriate.

- Services outside accepted medical standards and practices.
- To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veterans Administration facilities for service-connected illness or injury, unless the covered individual has an obligation to pay Injuries, conditions, diseases, disorder, or illnesses that occur because of any act of war.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Received from a member of your Immediate Family.
- Incurred before your coverage Effective Date.
- Incurred after you stop being a covered individual under the Medical Plan.
- The following physical examinations or Services:
    - Solely required by an insurance company to obtain insurance.
    - Solely required by a governmental agency such as the FAA, DOT, etc.
    - Solely required by an employer to begin or to continue working.
    - Premarital examinations.
    - Screening examinations, except as specified.
    - X-ray Medical imaging examinations made without film documented image; or
    - Routine or annual physical or vision examinations, except as specified.
- Where for which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This does not apply, however, if in accordance with federal law, the Medical Plan is primary, and Medicare is the secondary payer of your health care expenses.
- Received in a military facility for a military service-related injury, ailment, condition, disease, disorder, or illness for which Government benefits are available.
- Surgery and other Services or devices primarily to improve appearance and any complications incident to such Services.
- There are no benefits for wigs and hair prostheses.
- Inpatient admissions primarily for Diagnostic Services, Physical Therapy or Occupational Therapy, when these services could have performed on an Outpatient basis, and it was not Medically Necessary and Appropriate that you are admitted for the services.
- Custodial Care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
- Primarily for educational, vocational, or training purposes, including Speech Therapy for language and / or developmental delay, stuttering and articulation errors, except as specified.
- Conditions related to Autism Spectrum Disorders, learning disabilities or intellectual disabilities which extends beyond traditional medical management or for Inpatient confinement for environmental change.
- Topical anesthetics or stand-by anesthesia, except as specified.
- Arch supports, molded removable foot orthotics, and other foot care or foot support devices only to improve comfort or appearance such as care of flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses, ingrown toenails, and similar foot conditions, including Visits Incurred specifically to prepare or fit of such devices.

- The Treatment of obesity, including dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss. The only exception would be if Surgery is determined to be Medically Necessary and Appropriate.
- Marital counseling or any Service for marital maladjustments. Specific non-covered therapies are marital therapy or sexual therapy, or any therapy which is not listed as a covered service.
- Massage therapy, pet therapy, dance therapy, art therapy, nature therapy or any therapy not listed as a covered service.
- Hypnosis and acupuncture, unless otherwise stated in the Medical Plan.
- The Treatment of sexual problems not caused by organic disease or physical trauma.
- Reversal of sterilization.
- Unless otherwise stated in the Medical Plan, in-vitro fertilization, gamete intra-fallopian transfer and other ova transfer procedures.
- The Treatment of cysts or abscesses associated with the teeth, dental X-rays, dentistry or any other dental processes, except as specified.
- Appliances designed for orthodontic purposes such as braces, bionators, functional regulators, Frankel, and similar devices.
- Personal hygiene and convenience items. Examples include diapers, cervical pillows, lift chairs, Jacuzzis, exercise equipment and special linens, pillows, and air filters for allergy conditions.
- Unless otherwise stated, eyeglasses, contact lenses, or examinations for prescribing or the fitting of them, excluding those for aphakic patients and soft lenses or sclera sheets for use as corneal bandages.
- Hearing aids and services in preparation of fitting or testing.
- Missed appointment Fees or completion of administrative forms.
- Human organ transplant Services, other than as listed in the Peak Health Certificate of Coverage.
- Fraudulent or misrepresented Claims.
- Rehabilitation Services for Vocational Rehabilitation, long-term maintenance, or Custodial Care.
- Illness or injury arising in the course of employment or care received without cost under the laws of the federal or any state government or any political subdivision thereof, including any Workers' Compensation program or any employer self-funded Workers' Compensation plan.
- Prescription Drugs, except as specified under the Medical Plan.
- Unless otherwise stated in the Medical Plan, the Treatment of Temporomandibular Joint Syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension.
- Routine immunizations, except as specified.
- Any Service or Supply that can be purchased without a Prescription Order. Examples include nutritional supplements, Ensure, Pediasure or baby formula, batteries, earplugs, and any over the counter item.
- Any Service for or related to surrogate motherhood unless the Services are otherwise eligible and provided to the covered individual under the terms of the Medical Plan.
- Partial birth abortion.
- Cloning or any Services related to cloning.

- Cleft Palate Orthodontic Treatment, unless occurring within an approved orthodontic plan that is intended to treat a severe dentofacial abnormality and the member is under the age of 19.
- Injuries sustained while committing an illegal act or because of action on the part of any civil authority.
- Services or supplies more than any maximum limits or benefits.

If you have any questions about benefit exclusions, please contact Peak Health's Member Service at 1-833-569-7325.

III. COORDINATION OF BENEFITS

DUAL COVERAGE

It is common for family members to be covered by more than one health care plan. This happens, for example, when spouses both work and choose to have family coverage through both employers. When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "**Coordination of Benefits**" to determine how much each should pay when you have a Claim.

The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses. Coordination of Benefits is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, please contact the Plan Administrator or Peak health's Member Services.

PRIMARY OR SECONDARY?

You will be asked by the Plan Administrator or by Peak Health to complete questionnaires occasionally to identify all the plans that cover family members. The Medical Plan needs this information to determine whether Peak Health is the "**Primary Plan**" or the "**Secondary Plan**" benefit payer. To avoid Claim denials, you need to complete and return the questionnaires promptly. Also, please notify the Plan Administrator or Peak Health promptly about any changes to the other health care coverage.

PEAK HEALTH'S ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan. With the following exceptions:

- A plan that does not contain Coordination of Benefits provisions that are consistent with this rule is always the Primary Plan unless the provisions of both plans state that the complying plan is the Primary Plan; or
- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided to the eligible employee.

Examples of these situations are major medical coverages superimposed over base plan Hospital and surgical benefits, and insurance type coverage written in connection with a closed panel plan to provide Out-of-Network benefits.

2. A plan may consider the benefits paid or provided by another plan in calculation payment of its benefits only when it is the Secondary Plan to that other plan.

3. Each plan determines its order of benefits using the first of the following rules that apply:

- Non-Dependent/Dependent
  - The plan which covers the person other than as a Dependent, for example as an employee, participant, eligible employee, subscriber, or retiree is the Primary Plan and the plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, because of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, participant, eligible employee, subscriber, or retiree is the Secondary Plan and the other plan is the Primary Plan.
- Dependent Child Covered Under More Than One Plan
  - Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan the order of benefits is determined as follows:

    For a Dependent child, whose parents are married or are living together, regardless of if they have ever been married:

    - The plan of the parent whose birthday falls earlier in a calendar year is the Primary Plan.
    - If both parents have the same birthday, the plan that has covered the parent longest is the Primary Plan.

    For a Dependent child, whose parents are divorced or separated or not living together, regardless of if they have ever been married:

    - If there is no court decree allocating responsibility for the dependent child's health care coverage, the order of benefits for the child are as follows:
    - The plan of the parent with custody of the child.
    - The plan of the spouse of the parent with the custody of the child.
    - The plan of the parent not having custody of the child.
    - The plan of the spouse of the parent not having custody of the child.
- If the specific terms of a court decree state that one of the parents is responsible for the health care coverage of the Dependent child, and the plan of that parent has actual knowledge of those terms, that plan is the Primary Plan.
- This rule applies to plan years commencing after the plan is given notice of the court decree,
- If a court decree states that both parents are responsible for the Dependent child's health care coverage, the provisions above shall determine the order of benefits.
- If the court decree states that the parents have joint equal custody, without stating that one of the parents is responsible for the health care coverages of the Dependent child, the provisions above shall determine the order of benefits.
- For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions above shall determine the order of benefits as if those individuals were the parents of the child.

4. Active Employees or Retired or Laid-Off Employee

The plan that covers a person as an active employee, that is an employee who is neither laid off nor retired, is the Primary Plan. The plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active employee and

that same person is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree to this rule, it is ignored.

5. COBRA or State Continuation Coverage

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, participant, subscriber, or retiree or covering the person as a Dependent of an employee, participant, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the Secondary Plan.

If the other plans do not have this rule, and as a result, the plans do not agree on the order of benefits this rule is ignored. This rule does not apply if the rule labeled of this section can determine the order of benefits.

6. Longer or Shorter Length of Coverage

The plan that covered a person as an employee, participant, subscriber, or retiree longer is the Primary Plan and the plan that covered that person for the shorter period is the Secondary Plan.

7. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the plans meeting the definition of plan. In addition, the Medical Plan will not pay more than it would have paid had it been the Primary Plan.

HOW PEAK HEALTH PAYS CLAIMS WHEN THE MEDICAL PLAN IS THE PRIMARY PAYER

When the medical Plan is the Primary Plan, the Medical Plan / Peak Health will pay the benefits in accordance with the terms of the Medical Plan, just as if you had no other health care coverage under any other plan.

HOW PEAK HEALTH PAYS CLAIMS WHEN THE MEDICAL PLAN IS THE SECONDARY PAYER

When the Medical Plan is the Secondary Plan, the Medical Plan / Peak Health does not pay until after the Primary Plan has paid its benefits. The Medical Plan will then pay part of, or all the Allowable Expenses left unpaid, as explained below.

An "**Allowable Expense**" is a health care expense covered by one of the plans, including Copayments, Coinsurance and Deductibles. The Medical Plan / Peak Health will determine its payment by calculating what the Medical Plan would have paid as the Primary Plan and then compare that amount to the Member Liability from the Primary Plan and pay the lesser amount.

Peak Health will not pay more than what the Medical Plan would have paid as the Primary Plan. The Medical Plan may reduce its payment by any amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid do not exceed the total Allowable Expense for your Claim. The Medical Plan will credit any amount it would have paid in the absence of your other health care coverage toward the Medical Plan Deductible. If the Primary Plan covers similar kinds of health care expenses, but allows expenses that the medical Plan does not cover, the Medical Plan may pay for those expenses.

The Medical Plan will not pay an amount the Primary Plan did not cover because you did not follow its rules and procedures. For example, if your Primary Plan has reduced its benefit because you did not obtain Prior Authorization, as required by that plan, the Medical Plan will not pay the amount of the reduction, because it is not an Allowable Expense.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under the

Medical Plan. If it does, the Medical Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under the Medical Plan.

RIGHT OF RECOVERY

If the amount of the payments made by Peak Health is more than it should have paid under this Coordination of Benefits provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered individual. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of Covered Medical Services.

IV. SUBROGATION AND REIMBURSEMENT

To the extent that the Medical Plan pays any medical or other expenses, it shall have the right to be reimbursed in full for those expenses from any recovery that you may have obtained from the Responsible Party. This is known as our right of reimbursement.

If you or your Eligible Dependents fail or refuse to make or pursue a Claim against any Responsible Party, then the Medical Plan shall have the right to make and / or pursue such Claim against the party responsible. This right exists to the extent that the Medical Plan has paid any medical or other expenses for you or any Eligible Dependents under this Member Manual. This is known as the Medical Plan's right of subrogation ("**Subrogation**").

The Medical Plan's right of reimbursement, as well as the right of subrogation, is hereinafter referred to as "**Reimbursement**."

Under Reimbursement, the Medical Plan may, at its discretion:

- Assert a Claim on behalf of you or your Eligible Dependents against any Responsible Party (including suing in your or your Eligible Dependent's name); or
- Intervene in any lawsuit or Claim that you or your Eligible Dependents has filed or made against any Responsible Party.
- Reimbursement shall constitute a lien against the proceeds of any: (i) Settlement or compromise between you or your Eligible Dependents and any Responsible Party; or (ii) Judgment or award obtained by you or your Eligible Dependents against a Responsible Party; or (iii) Third party reimbursement or proceeds. The types of proceeds described above are hereinafter referred to as Subrogated Recovery.

The Medical Plan's right of reimbursement shall exist notwithstanding any allocation or apportionment of any Subrogated Recovery that asserts to limit or eliminate the Medical Plan's right of reimbursement. All recoveries that you or your Eligible Dependents or your representative obtain (whether by lawsuit, settlement, insurance, or benefit program Claims, or otherwise), no matter how described or designated, must be used to reimburse the Medical Plan in full for benefits paid under the Medical Plan.

Any Subrogated Recovery that excludes or limits, or attempts to exclude or limit, the cost of medical services or care shall not preclude the Medical Plan from enforcing its right of reimbursement. The Medical Plan's right of reimbursement shall not be eliminated or limited in any way because the Subrogated Recovery fails to fully compensate or "make whole" you or your

Eligible Dependent on their total Claim against any Responsible Party. Similarly, the Medical Plan's Right of Recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. As a condition to coverage, an individual covered under the Medical Plan agrees not to do anything to prejudice the Medical Plan's rights and agrees to cooperate fully with the Company, the Plan Administrator and Peak Health.

A covered individual must notify the Plan Administrator or Peak Health's Claims Department, in writing, of the existence of any Responsible Party. If a covered individual retains legal counsel to recover from any Responsible Party, the covered individual must immediately notify legal counsel of the Medical Plan's Right of Reimbursement. In addition, the covered individual must immediately notify the Plan Administrator or Peak Health's Claims Department, in writing, that legal counsel has been retained.

The covered individual must also provide the Medical Plan with prompt notice of any Subrogated Recovery. A covered individual further agrees to notify the Medical Plan of any facts that may impact on its Right of Reimbursement, including but not limited to:

- Filing of a lawsuit. Making a Claim against any third party, for Worker's Compensation benefits, or against any other potential source of recovery; e.g, Automobile Insurance
- Timely advance notification of settlement negotiations; and
- Timely advance notification of the intent of a third party to make payment of any kind for the benefit of or on behalf of the covered individual that is in any manner related to the condition giving rise to our Right of Reimbursement.

A covered individual and / or their legal counsel may be required to execute and deliver to the Medical Plan written confirmation of the Right of Reimbursement. In addition, a covered individual may be required to execute and deliver to the Medical Plan other documents that may be necessary to secure and protect the Medical Plan's Right of Reimbursement.

The Medical Plan's failure to request such written confirmation or other documents shall not be a waiver by of its Right of Reimbursement. Failure to provide such written confirmation or other documents upon request, or failure to cooperate with the Medical Plan in the protection of its Right of Reimbursement, may result in:

- Cancellation of benefits; and / or
- Denial of the Claim upon which the Medical Plan's Right of Reimbursement is based.

Any such cancellation or denial shall not affect the Medical Plan's Right of Reimbursement to the extent of any medical expenses actually paid by the Medical Plan.

A covered individual agrees to keep in a segregated account that portion of any Subrogated Recovery that is equal to any benefits the Medical Plan has paid for the covered individual's injuries, until the Medical Plan's Right of Reimbursement has been satisfied. A covered individual and / or their legal counsel shall promptly pay the Medical Plan all amounts recovered because of any Subrogated Recovery to the extent the medical Plan has paid any medical or other expenses for that covered individual.

The Medical Plan shall have no duty or obligation to pay any legal fees or expenses incurred by such covered individual in obtaining a Subrogated Recovery. Should the Medical Plan be required to take any action to enforce its Right of Reimbursement, including filing a civil action, the medical

Plan shall be entitled to recover all costs associated with such enforcement efforts. These costs include, but are not limited to, all attorney's fees and expenses Incurred by the Company, Peak Health or the Medical Plan.

If necessary, the Medical Plan shall have the right to seek appropriate equitable relief to redress any violation of this provision by a covered individual. Recoveries under this provision will be applied to your Claim history, less any Charges or Fees Incurred in obtaining the recoveries. If the Medical Plan is unable to recover benefits notwithstanding a covered individual's recovery from a Responsible Party, and if the covered individual thereafter incurs health care expenses for any reason, the Medical Plan may exclude benefits for otherwise covered expenses until the total amount of those health care expenses exceeds the recovery from the Responsible Party.

V. CLAIMS PROCEDURES AND APPEAL PROCEDURES

APPEALS AND COMPLAINTS/GRIEVANCES

If a prior authorization or a claim is denied, in whole or in part, you will receive written notice with the following information and have the right to Appeal:

- The specific reason or reasons for the decision.
- Reference to any criteria, guidelines, or plan rules that support the decision, and the right to request a copy of these free of charge.
- Descriptions of any further information (if any) required to approve the requested service or claim and why more information is needed.
- A description of Appeal procedures and relevant time limits.
- A description of legal rights associated with the denial.

An explanation of any scientific or clinical judgment involved in the decision and applied in the circumstances, if applicable (i.e., Medical Necessity, Experimental Treatment, etc.), can be provided free of charge upon request.

If services are approved after Appeal, payment of Claims will be dependent upon all provisions, limitations, and conditions of this Member Manual.

For instance, all Deductibles, co-insurance, Co-Pays, and other limitations still apply.

INTERNAL APPEAL PROCESS

Peak Health maintains an internal Appeal process involving one (1) level of review. At any time during the Appeal process, a covered individual may choose to designate an authorized representative to participate in the Appeal process on his/her behalf. The covered individual or their authorized representative shall notify Peak Health, in writing, by completion of the authorized representative form found at **peakhealth.org**

For purposes of the Appeal process, a covered individual includes designees, legal representatives and, in the case of a minor, parents of a covered individual entitled or authorized to act on the covered individual's behalf. If an Appeal is submitted by a representative prior to the plans receipt of written notice of the representative, the Appeals process will not begin until this notice is received.

Peak Health reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a covered individual. Such procedures as adopted by Peak Health shall, in the case of an Urgent Care Claim, permit a Provider with knowledge of the covered individual's medical condition to act as the covered individual's authorized representative.

If a covered individual has received notification that a prior authorization or claim has been denied by Peak Health, in whole or in part, the covered individual or their authorized representative may Appeal the decision.

The covered individual's Appeal must be submitted within one hundred eighty (180) days from the date of the covered individual's receipt of notification of the adverse decision.

The covered individual, upon request to Peak Health, may review all documents, records, and other information relevant to the Appeal and shall have the right to submit or present additional evidence or testimony which includes any written or oral statements, comments and / or remarks, documents, records, information, data, or other material in support of the Appeal.

An Appeal may be submitted by mail, fax, or electronically via the member portal or Peak Provider portal.

Expedited Appeals only may be filed by calling Peak Health Member Service at 1-833-5-MYPEAK (1-833-569-7325). Peak Health's Appeal form can be found at **peakhealth.org**. The Appeal form or request should include the covered individual's name, address, Member ID (on your Identification Card), and all pertinent medical information, as well as any supporting documentation and written comments for review.

Mail: Peak Health Appeals & Grievances
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505

Fax: 304-974-3191

Phone: Peak Health Member Service 1-833-5-MYPEAK (1-833-569-7325)

TDD and TTY assistance and language services are available when calling Peak Health Member Service for help with the Appeals process.

At any time during the Appeal process, a covered individual, Provider, or their authorized representative may contact the Member Service or Provider Service Departments to inquire about the filing or status of an Appeal, request a copy of their Appeal file including all relevant medical records and information obtained while investigating the Appeal, or a copy of the criterion, rule, or guidance against which the Appeal was reviewed.

Provider Service 1-833-9-MYPEAK (1-833-969-7325)

Member Service 1-833-5-MYPEAK (1-833-569-7325)

The Appeal will be reviewed by a representative that was not involved in the original review or is the subordinate of any individual that was involved in any previous decision to deny the prior authorization or claim or matter which is the subject of the covered individual's Appeal.

In rendering a decision on the Appeal, Peak Health will consider all evidence, comments, testimony, documents, records, and other information submitted by the covered individual without regard to whether such information was previously submitted to or considered by Peak Health.

Peak Health will perform a new review and will not assume the original determination's correctness.

For Appeals of Adverse Benefit Determinations which were based on medical judgment, including Medical Necessity or Experimental Treatment, Peak Health will consult with a Physician or other health professional that holds an unrestricted license and has appropriate training and experience in the field of medicine involved in the medical judgment, medical condition, procedures, or Treatment under review.

If additional information is needed to perfect or process the prior authorization or claim, Peak Health will request the specific information from you and / or your Provider. If Peak Health is not

provided with the additional requested information, Peak health will complete its review based on the information in its files. Each Appeal will be promptly investigated, and Peak Health will provide written notification of its decision within the following time frames:

- When the Appeal involves a standard pre-service authorization, within a reasonable period appropriate to the medical circumstances involved not to exceed fifteen (15) days following receipt of the Appeal.
- When the Appeal involves an expedited or concurrent authorization, as soon as possible considering the medical emergencies involved but not later than seventy-two (72) hours following receipt of the Appeal.
- When the Appeal involves a Post-Service Claim or a decision by Peak Health within a reasonable period not to exceed thirty (60) days following receipt of the Appeal.

A request for an expedited review will be considered for any medical care or Treatment where reviewing within the standard period could seriously jeopardize the claimant's life or health or ability to regain maximum function, or when reviewing within the standard period would subject the covered individual to adverse health consequences without the care or Treatment requested. If an extension is required due to exceptional circumstances, the medical Plan will notify the covered individual in writing of the extension. An extension will not be made without the covered individual's permission, and unless it is deemed in the best interest of the covered individual.

If Peak Health renders an adverse decision on the Appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding the right of the covered individual to request an external review.

EXTERNAL REVIEW PROCESS

If an Adverse Benefit Determination is issued through Peak Health's internal Appeals process or Peak Health fails to provide notice of a decision within the above-specified time frames, the covered individual has the right to seek an external Appeal review through an Independent Review Organization (IRO) free of charge. Also, if Peak Health fails to adhere to these Appeal procedures, the covered individual may request an external review.

A covered individual will have four (4) months from the receipt of the notice of Peak Health's decision to request an external review of the decision. The request shall be in writing unless an expedited review is necessary. The covered individual should include any necessary supporting information as part of the external review filing.

Requests for an external review may be filed at the following address:

Peak Health Appeals & Grievances
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505

Additionally, standard requests may be filed by fax or electronically via the member portal. Expedited requests only may be filed by calling Peak Health Member Service at 1-833-5-MYPEAK (1-8335697325). Please specify that an external Appeal review is being requested.

The Appeals department will review the request and verify eligibility for external Appeal review within 5 business days. The covered individual will be notified of eligibility within 6 business days, and the request will be assigned at random to one of three contracted Independent Review Organizations (**IRO**) within 10 business days of original receipt.

All records from the initial review shall be forwarded to the assigned external Independent Review Organization (IRO). The covered individual will be notified once the request is submitted to the IRO with the name and contact information of the review organization as well as a list of all documents

submitted on their behalf. The covered individual has the right to submit any additional information deemed necessary directly to the IRO. The IRO will issue a decision to both the covered individual and the Medical Plan within 45 business days from their receipt of the Appeal for standard requests.

The IRO conducting the external review shall review all the information considered in reaching any prior decisions to deny payment for the health care Service and any other written submission by the covered individual or the care Provider.

Within 45 calendar days of the filing of the external review, the IRO conducting the external review shall issue a written notification of the decision to Peak Health, the covered individual, or the health care Provider, including the basis and clinical rationale for the decision.

If an Adverse Determination for an expedited request is issued through Peak Health's internal Appeals process, Peak Health will automatically send a copy of the completed case file with an explanation of the Adverse Determination to the randomly assigned IRO within 24 hours of the determination to uphold the initial denial. Peak Health and the covered individual or health care Provider will be notified of a decision by the IRO within 72 hours.

Peak Health will authorize any health care service or pay a Claim determined to be Medically Necessary and Appropriate based on the decision of the IRO.

If an Adverse Benefit Determination is issued through Peak Health's Appeals process, covered individuals also have the right to seek legal counsel. For questions regarding Appeal rights, you may contact the Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA (3272) or the U.S. Department of Labor at 1-866-487-2365 for more information.

U.S. Department of Labor https://www.dol.gov/

Employee Benefits Security Administration https://www.dol.gov/agencies/ebsa

COMPLAINTS AND GRIEVANCE PROCESS

The following information will help you understand your rights as a covered individual, provide definitions of some general terms, inform you about steps you can take if issues arise and what to expect from the Medical Plan and Peak Health.

A "**Complaint**" is any expression of dissatisfaction regarding the Medical Plan or Network of Providers made orally or in writing. Examples of a Complaint include concerns about wait times, demeanor of health care personnel, the adequacy of facilities, or respect paid to the covered individual.

A "**Grievance**" is a formal Complaint or dispute other than one involving a request for coverage that expresses dissatisfaction with the manner in which Peak Health or a delegated entity provides services. Examples of a Grievance include dissatisfaction with a refusal to expedite a request for coverage, concerns regarding timeliness of a request, concerns with the quality of care received, or concerns regarding access to care.

Dissatisfaction with an Adverse Benefit Determination considered necessary by the covered individual or Provider will be classified as an Appeal rather than a Grievance.

If you are not satisfied with the services provided to you by Peak Health, it will be their pleasure to work with you and do their best to resolve any issues. Peak Health encourages you to first call and discuss the reason for your dissatisfaction with a Member Service or Provider Service Representative.

A Complaint or Grievance may be reported by a covered individual or their authorized representative by calling Member Service at 1-833-5-MYPEAK (1-833-569-7325) or Provider Service at 1-833-9-MYPEAK (1833969-7325) Monday through Friday, 8:00am to 5:00 pm ET, excluding holidays.

A written Complaint or Grievance may also be submitted electronically via the member portal, by

fax, or by mail. Peak Health must be informed of any authorized representative in writing by completion of the authorized representative form found at **peakhealth.org** prior to initiation of the Grievance.

Mail: Peak Health Appeals & Grievances
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505

Fax: 304-974-3191

Phone: 1-833-5-MYPEAK (1-833-569-7325) Member Service

You will receive a notification informing you that Peak Health has received and are reviewing your Grievance request. Peak Health will complete an investigation of formal Grievances as quickly as the circumstance requires and send a resolution notice within 30 calendar days from receipt of the request. For urgent Grievance requests, Peak Health will send a resolution notice within 72 hours. If Peak Health needs more time to investigate the situation, Peak Health will notify covered individuals about the extension prior to the end of the initial time period.

If you are still dissatisfied after a resolution decision has been received or have questions about your rights, you may contact the Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA (3272) or the U.S. Department of Labor at 1-866-487-2365 for assistance.

U.S. Department of Labor https://www.dol.gov/

Employee Benefits Security Administration https://www.dol.gov/agencies/ebsa