HOPE GAS, INC. RETIREE HEALTH AND WELFARE BENEFIT PLAN

RETIREE 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 Retiree Medical Plan under the Hope Gas, Inc. Retiree Health and Welfare Benefit Plan (the "**Retiree Health and Welfare Benefit Plan**") provides Eligible Retirees of Hope Gas, Inc. (the "**Company**") and their Eligible Dependents with benefits for covered Medical services.

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

It is important that you review the Anthem Benefit Booklet in conjunction with this Retiree Medical SPD.

The benefits provided under the Retiree Medical Plan as described in this Retiree Medical SPD are pursuant to provisions of a collective bargaining agreement entered into between the Company and the United Gas Workers Union, Local 69, UWUA, AFL-CIO (the "**Union**") and agreements between the Company and the Union dated August 22, 2023 and December 13, 2023. You may obtain copies of the collective bargaining agreement and the August 22, 2023 and December 13, 2023 agreements from your Union representative or the Plan Administrator by submitting a written request. The collective bargaining agreement and the August 22, 2023 and December 13, 2023 agreements are also available for inspection at the principal office of the Plan Administrator.

SUMMARY PLAN DESCRIPTION

The Summary Plan Description for the Retiree Medical Plan consists of this Retiree Medical Plan Summary Plan Description (the "**Retiree 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**").

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

OTHER BENEFITS UNDER THE RETIREE HEALTH AND WELFARE BENEFIT PLAN

In addition to the Retiree Medical Plan, the Retiree Health and Welfare Benefit Plan provides eligible retirees of the Company with retiree life insurance and health reimbursement arrangement benefits.

- ***For information on retiree life insurance and eligibility for coverage, please refer to the Retiree Health and Welfare Benefit Plan Life Insurance Summary Plan Description.***
- ***For information on health reimbursement arrangement benefits, please refer to the Retiree Health and Welfare Benefit Plan Health Reimbursement Arrangement Summary Plan Description.***

RETIREE MEDICAL PLAN HIGHLIGHTS

ELIGIBILITY REQUIREMENTS	I. Date of Employment on or Before March 23, 2017 • Employees represented by the United Gas Workers Union Local 69, UWUA, AFL-CIO; • Regularly scheduled to work an average of 30 hours or more per week; • 10 years of Credited Service; • Age 58 or older; • Retired from the Company; and • Covered under the Company's Medical Plan for active employees immediately prior to retirement. II. Date of Employment After March 23, 2017 • Employees represented by the United Gas Workers Union Local 69, UWUA, AFL-CIO; • Regularly scheduled to work an average of 30 hours or more per week; • 10 years of Credited Service after attaining age 45; • Age 58 or older; • Retired from the Company; and • Covered under the Company's Medical Plan for active employees immediately prior to retirement.
ENROLLMENT	Enrollment must be completed within 30 days after the date of retirement from the Company.
WHEN COVERAGE BEGINS	If enrollment is completed within 30 days after the date of retirement from the Company, Retiree Medical coverage is effective as of the first day of the month following the date of retirement.
WHEN COVERAGE ENDS	Retiree Medical coverage (including coverage of Eligible Dependents) ends as of the date the Eligible Retiree is Medicare Eligible (in most cases, age 65).
COST OF COVERAGE	The Company pays the full cost of Retiree Medical Coverage; however, participants are responsible for any applicable deductible or co-insurance payments.
FUNDING	The Retiree Medical Plan is self-funded by the Company.
PLAN YEAR	The Plan Year for the Retiree 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 (i) regularly scheduled to work an average of 30 hours or more per week, (ii) represented by the United Gas Workers' Union Local 69, UWUA, AFL-CIO ("**Union Employees**"), and (iii) covered under the Company's Medical Plan for active employees are an

"**Eligible Retiree**" and eligible to enroll for Retiree Medical coverage upon satisfying the following requirements:

- Union Employees whose date of employment is on or before March 23, 2017 are an Eligible Retiree as of the date they have (i) completed 10 years of Credited Service, (ii) attained age 58, and (iii) retired from the Company.
- Union Employees whose date of employment is after March 23, 2017 are an Eligible Retiree as of the date they have (i) completed 10 years of Credited Service after attaining age 45, (ii) attained age 58, and (iii) retired from the Company.

CREDITED SERVICE

For purposes of Retiree Medical eligibility, a Union Employee's years of "Credited Service" are equal to their years of Credited Service under the Hope Gas Pension Plan.

For more information on determining your years of Credited Service, please refer to the Hope Gas Pension Plan Summary Plan Description or contact Hope Gas Benefits.

ELIGIBLE DEPENDENTS

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

- **Spouse:** an Eligible Retiree's legally married spouse or domestic partner.
- **Children**: an Eligible Retiree'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 Retiree for adoption), (iii) step-children, (iv) foster children, (v) children for whom an Eligible Retiree 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 an Eligible Retiree in a parent/child relationship and qualifies as the Eligible Retiree's dependent as defined in the Internal Revenue Code.
- **Incapacitated Children:** an Eligible Retiree'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 Retiree 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 AND COVERAGE EFFECTIVE DATE

ENROLLMENT PROCEDURE

You can enroll for Retiree Medical coverage at any time within 30 days after becoming an Eligible Retiree by contacting 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

Please note: if you wish to enroll for Retiree Medical, you must do so within 30 days after you become an Eligible Retiree (i.e., within 30 days after the date you retire from the Company). If you do not enroll for Retiree Medical during this time period, you will no longer be eligible to enroll.

ENROLLMENT OPTIONS

Your Retiree 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)

COVERAGE EFFECTIVE DATE

Your Retiree Medical coverage will be effective as of the first day of the month coinciding with or next following the date you became an Eligible Retiree.

ID CARDS

After you enroll for Retiree Medical coverage, you will be provided with an Identification Card for Retiree Medical coverage by Anthem.

QUALIFYING LIFE EVENTS

If you timely enroll for Retiree Medical and later experience a Qualifying Life Event, you are permitted to change certain Retiree Medical coverage elections; 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 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.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If you timely enroll for Retiree Medical and you or your Spouse later become required by a qualified medical child support order ("**QMCSO**") or similar court order under applicable law to provide an Eligible Dependent Child with medical coverage, you are permitted to add such child to your Retiree 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 Retiree 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.

IV. MEDICAL COVERAGE COSTS

If you elect Retiree Medical coverage, the Company will pay the full cost of coverage, except for any applicable deductibles, Co-Pay, coinsurance or out-of-network charges.

V. RETIREE MEDICAL BENEFITS

The Retiree 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. 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

A Schedule of Covered Medical Services, including applicable Co-Pay and coinsurance amounts, is set forth on Appendix A.

FOR FURTHER INFORMATION AND DETAILS ON COVERED MEDICAL SERVICES, PLEASE REFER TO THE ANTHEM BENEFIT BOOKLET.

EXCLUDED SERVICES

A listing of certain procedures, equipment, services, supplies and changes that are excluded from coverage under the Retiree Medical Plan are set forth on Appendix B.

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 for payment under the Retiree Medical Plan; however, you will be responsible for payment of any deductible, Co-Pay or coinsurance to the provider.

To access a directory of Anthem's In-Network Providers, go to www.anthem.com.

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. 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 Retiree 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.

Please go to www.anthem.com for a list of Anthem 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. Your Retiree Medical Coverage includes 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 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 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.

DEDUCTIBLE

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

In-Network Deductible (Includes Pharmacy Deductible for Covered Prescription Drug Benefits)	Out-of-Network Deductible (Includes Pharmacy Deductible for Covered Prescription Drug Benefits)
$750 individual $1,500 family	$750 individual $1,500 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 be different for In-Network services and Out-of-Network services.

The applicable Co-Pay and coinsurance amounts for are set forth on Appendix A 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:

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)
$3,000 individual $6,000 family	$6,000 individual $12,000 family

COORDINATION OF BENEFITS

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

Please refer to Appendix B for Anthem's Coordination of Benefits Procedures.

OVERPAYMENT OF BENEFITS

To the extent that benefits under the Retiree Medical Plan are paid in error or are overpaid, the Retiree 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 Retiree Medical Plan but is also payable by a liable third party, the Retiree 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 Retiree Medical Plan may be entitled to offset or recovery. Please refer to Appendix B for Anthem's Statement of Subrogation Rights.

PREDETERMINATION OF BENEFITS AND CARE MANAGEMENT

Please refer to Appendix B for Anthem's provisions on predetermination and precertification of Covered Medical Services.

EXCLUDED SERVICES

Please refer to Appendix B for Anthem's provisions on services excluded from coverage under the Retiree Medical Plan.

VI. WHEN RETIREE MEDICAL COVERAGE ENDS

Eligible Retirees: An Eligible Retiree's Retiree Medical coverage will end as of the earliest date on which they are considered eligible for any coverage under Medicare. In general, you should be eligible for Medicare as of the date you attain age 65 or, if sooner, upon receiving Social Security disability benefits for a period greater than 24 months.

- If an Eligible Retiree is covered under the Retiree Life Insurance Plan, their life insurance coverage continues after they are no longer eligible for Retiree Medical Coverage.

- An Eligible Retiree's participation in the Health Reimbursement Arrangement continues after they are no longer eligible for Retiree Medical Coverage,

Spouses: Retiree Medical coverage of an Eligible Retiree's Spouse will end as of the earliest date on which they are considered eligible for any coverage under Medicare. If an Eligible Retiree is no longer eligible for Retiree Medical coverage due to Medicare eligibility but their Spouse is not yet considered eligible for any coverage under Medicare, the Spouse's Retiree Medical coverage will continue until the earliest date on which such Spouse is considered eligible for any coverage under Medicare.

Please refer to the Retiree Health and Welfare Benefit Plan Health Reimbursement Arrangement Summary Plan Description for information on a Spouse's eligibility for Health Reimbursement Arrangement benefits.

Children: Retiree Medical coverage of an Eligible Retiree's dependents will end as of the earliest date on which they are no longer considered an Eligible Dependent.

Please refer to the Retiree Health and Welfare Benefit Plan Health Reimbursement Arrangement Summary Plan Description for information on eligibility for Health Reimbursement Arrangement benefits for an Eligible Retiree's children.

VII. COBRA CONTINUATION COVERAGE

If your Eligible Dependents' coverage under the Retiree Medical Plan ends due to a "**Qualifying Event**," they may be eligible to 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.

VIII. FILING A CLAIM

If Covered Services are provided by an In-Network Provider, the provider will submit a claim directly to Anthem 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, 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 Retiree Medical Plan.

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.

For assistance with filing a claim with Anthem, 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

IX. CLAIMS PROCEDURES AND APPEALS

Please refer to Appendix B for Anthem's Claims Procedures and Appeal Process.

X. PLAN DOCUMENTS

The information in this Retiree Medical SPD has been prepared to describe Retiree Medical Plan benefits under the Retiree 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 Retiree Medical Plan and the Retiree Health and Welfare Benefit Plan, including but not limited to the Anthem Benefit Booklet, as applicable, those official documents and contracts will govern.

XI. CHANGING OR TERMINATING THE RETIREE MEDICAL PLAN

The Company reserves the right to alter, amend, or terminate the Retiree Medical Plan at any future date. Such alteration, amendment or termination by the Company shall be permitted only after obtaining consent by the Union to such changes, unless the alteration, amendment or termination is needed to comply with law, or if it is administrative in nature and does not alter the substantive benefits of the plan, in which cases the Company can make such alteration, amendment or termination without consent.

XII. 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 Retiree Medical Plan.

XIII. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE

Prior authorization is not required from the Plan Administrator or Anthem, 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.

XIV. 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).

XV. 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 Retiree Medical Plan.

XVI. 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 Retiree 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.

XVII. OTHER RIGHTS

The Company, for itself as Plan Administrator and on behalf of the Retiree Medical 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
ANTHEM BLUE CROSS AND BLUE SHIELD PPO PREMIUM PLAN

As of January 1, 2026, Covered Medical Services for Retiree Medical - 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

(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
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 B

ADDITIONAL RETIREE MEDICAL PLAN PROVISIONS

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 Retiree Medical Plan. Please refer to the Anthem Benefit Booklet for further information.

I. PREDETERMINATION AND PRECERTIFICATION OF BENEFITS

The Retiree 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 Retiree 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 Retiree Medical Plan;
4. The service cannot be subject to an Exclusion under the Retiree Medical Plan; and

5. You must not have exceeded any applicable limits under the Retiree 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
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 found to not be Medically Necessary.
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
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 Retiree Medical Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Maximums. Anthem will make any recommendation of alternate or extended benefits to the 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 Retiree 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 Retiree Medical Plan to provide the same benefits again to you or to any other covered individual. The Retiree 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 Retiree 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 Plan.

The Retiree Medical Plan does not provide benefits 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 Retiree 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 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree Medical Plan.

The Retiree 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 Retiree 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 Retiree 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 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 Retiree 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 Retiree 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 Retiree 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 <u>not</u> 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree Medical Plan and other Health Coverage Plans. The Retiree 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 Retiree Medical Plan and other Health Coverage Plans covering the person claiming benefits. The Retiree Medical Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under the Retiree 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 Retiree Medical Plan. If it does, the Retiree 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 Retiree Medical Plan. The Retiree 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 Retiree Medical Plan is more than should have paid under this Coordination of Benefits provision, the Retiree Medical Plan may recover the excess from one or more of the persons the Plan paid or for whom the 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 Retiree 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 Retiree 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 Retiree Medical Plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former Retiree 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 Retiree Medical Plan. The Retiree 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 Retiree Medical Plan, the Plan shall be subrogated to, or stand in the place of, all of your rights of Recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Retiree Medical Plan. The Retiree 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 Retiree 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 Retiree Medical Plan. The Retiree 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 Retiree 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 Retiree Medical Plan first from such payment for all amounts the Retiree 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 Retiree Medical Plan has not been repaid for the benefits the Retiree Medical Plan paid on your behalf, the Retiree 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 Retiree Medical Plan from any Recovery to the extent of benefits the Retiree 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 Retiree 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 Retiree 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 Retiree Medical Plan to the contrary.

ASSIGNMENT

In order to secure the Retiree Medical Plan's rights under these Subrogation and Reimbursement Provisions, you agree to assign to the Retiree 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 Retiree Medical Plan's subrogation and reimbursement claims. This assignment allows the Retiree 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 Retiree Medical Plan shall have a right of full Recovery, in first priority, against any Recovery you make. Furthermore, the Retiree 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 Retiree 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 Retiree Medical Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Retiree 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 Retiree 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 Retiree Medical Plan the full amount of the Recovery to be paid to the Retiree Medical Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Retiree Medical Plan. Any Recovery you obtain must not be dissipated or disbursed until such time as the Retiree Medical Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

LIEN RIGHTS

The Retiree Medical Plan will automatically have a lien to the extent of benefits paid by the Retiree 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 Retiree 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 Retiree Medical Plan's equitable lien applies is a Retiree Medical Plan asset. The Retiree 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 Retiree Medical Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Retiree Medical Plan may have a right or interest.

FIRST-PRIORITY CLAIM

By accepting benefits from the Retiree Medical Plan, you acknowledge the Retiree Medical Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Retiree Medical Plan before you receive any Recovery for your damages. The Retiree Medical Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Retiree 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 Retiree Medical Plan's subrogation claim and any claim held by you, the Retiree 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 Retiree 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 Retiree Medical Plan.

COOPERATION

You agree to cooperate fully with the Retiree 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 Retiree 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 Retiree Medical Plan.
- You must notify the Retiree 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 Retiree Medical Plan in the investigation, settlement and protection of the Retiree Medical Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Retiree Medical Plan to exercise its subrogation or reimbursement rights, the Retiree Medical Plan shall be entitled to deduct the amount the Retiree Medical Plan paid from any future benefits under the Retiree Medical Plan.
- You and your agents shall provide all information requested by the Retiree 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 Retiree Medical Plan may reasonably request and all documents related to or filed in personal injury litigation.

- You recognize that to the extent that the Retiree 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 Retiree 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 Retiree Medical Plan.
- You must send the Retiree 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 Retiree 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 Retiree 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 Retiree Medical Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Retiree Medical Plan shall be entitled to deduct the amount the Retiree Medical Plan paid from any future benefits under the Retiree Medical Plan.

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

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

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

You acknowledge the Retiree Medical Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of Recovery. The Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree Medical Plan to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about the Retiree 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 Retiree Medical Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree Medical Plan's notice will also include a description of the applicable urgent/concurrent review process; and
- The Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree Medical Plan will include all of the information set forth in the above section entitled “Notice of Adverse Benefit Determination.”

If, after the Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree Medical Plan's final decision on the claim or other request for benefits. If the Retiree Medical Plan decides a grievance or appeal is untimely, the Retiree Medical Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Retiree 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 Retiree 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 Retiree 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 Retiree Medical Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.