UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

OWENS & MINOR, INC. and	§	
OWENS & MINOR FLEXIBLE	§	Case No. 3:23-cv-00115
BENEFITS PLAN	§	
	§	
V.	§	COMPLAINT
	§	
ANTHEM HEALTH PLANS OF	§	
VIRGINIA, INC. D/B/A ANTHEM	§	[Jury Trial Demanded]
BLUE CROSS AND BLUE SHIELD	§	

PLAINTIFFS' ORIGINAL COMPLAINT

TABLE OF CONTENTS

Plaintiff OWENS & MINOR, INC., individually and on behalf of Plaintiff OWENS & MINOR FLEXIBLE BENEFITS PLAN,[1] files this Complaint against ANTHEM HEALTH PLANS OF VIRGINIA, INC. D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD, and in support thereof states the following:

INTRODUCTION

I. EMPLOYERS SPONSORING HEALTHCARE PLANS FOR EMPLOYEES ALMOST UNIVERSALLY HIRE THIRD PARTY ADMINISTRATORS LIKE DEFENDANT.

1. Throughout the country, employers large and small provide healthcare benefits for their employees. Many employers, including Plaintiff Owens & Minor, provide health benefits through self-funded plans, whereby the plan funds employees' and their beneficiaries' healthcare expenses primarily from employer and employee contributions.

2. As sponsors and plan administrators of self-funded plans, employers owe fiduciary duties under the Employee Retirement Income Security Act (**ERISA**) to the plans and to the employees and beneficiaries covered by those plans. But employers almost universally lack the ability to manage and administer their plans' healthcare claims. Not surprisingly, ERISA allows plan sponsors to delegate those fiduciary responsibilities to third parties who possess that ability.

3. For these reasons, there is a significant—and lucrative—market for third party administrators (**TPAs**). TPAs specialize in the healthcare benefits business. They

[1] In this Complaint, "Plaintiff" refers to Owens & Minor, Inc. in its individual and representative capacities unless otherwise provided expressly or by context.

possess the expertise, personnel, and systems to price, administer, and process healthcare claims. TPAs like Defendant market themselves as possessing the expertise and integrity necessary to serve as fiduciary plan administrators. Thus, employers sponsoring self-funded healthcare plans generally entrust the plans' assets and the health of their employees to TPAs.

4. In 2017, Plaintiff Owens & Minor hired Defendant Anthem, a TPA who purports to be a specialist in the administration of self-funded plans, to manage healthcare claims for Plaintiff's plan with the level of care and loyalty demanded by ERISA. In doing so, Plaintiff entrusted its plan's assets and the care of its employees to Defendant. Nevertheless, as plan sponsor, administrator, and named fiduciary, Plaintiff retained duties under ERISA to monitor Defendant, protect plan assets, and oversee the quality of care provided to its employees and beneficiaries. Plaintiff reasonably expected Defendant to comply with the law and be transparent and candid regarding Defendant's administration of the plan and use of plan assets. Those are core fiduciary duties. But Defendant has been anything but "transparent" and "candid."

II. IN RECENT YEARS, PLAINTIFF GREW MORE SENSITIVE TO THE THREAT POSED BY TPA FRAUD, WASTE, AND ABUSE.

5. Over the past few years, Plaintiff has learned of several instances where opportunistic claims administrators have employed illegal or unethical means to obtain windfall profits—at the expense of self-funded plans and taxpayers alike. Plaintiff learned of accusations against numerous insurers—including Defendant's Anthem affiliates—that they incentivized healthcare providers to report that Medicare

Advantage patients are sicker than they actually are because the insurers received more income for patients with more serious documented conditions. According to a recent *New York Times* report, the misconduct caused between $12 billion and $25 billion in overpayments by Medicare in 2020 alone.[2]

6. Other developments increased Plaintiff's commitment to carefully assess Defendant's claims administration practices.[3] One report revealed that merely replacing a claims administrator saved a governmental entity such a large sum of money that there simply had to be waste or other problems in the claims administration processes.[4] The news was saturated with stories regarding the harm that TPAs can cause.[5] The American Medical Association has estimated that commercial health insurers have an average claims-processing error rate of 19.3 percent, which creates excess costs of $17 billion

[2] Reed Abelson and Margot Sanger-Katz, *'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for* Billions, N.Y. TIMES (Oct. 8, 2022) *available at* https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html, last visited Oct. 10, 2022.

[3] *See, e.g.*, *Employer Held Liable for Service Provider's Error*, J.D. SUPRA (Dec. 31, 2020) *available at* https://www.jdsupra.com/legalnews/employer-held-liable-for-service-89209/, last visited Oct. 20, 2022.

[4] *TRS says it will save millions on new health administrators, assures members of minimal plan impacts*, TEXAS AFT (Feb. 27, 2020), *available at* https://www.texasaft.org/government/trs/trs-says-it-will-save-millions-on-new-health-administrators-assures-members-of-minimal-plan-impacts/, last visited Oct. 20, 2022 (Texas teacher retirement system saved hundreds of millions of dollars by replacing claims administrator).

[5] *See*, *e.g.*, Brendan Pierson, Mass. *Blue Cross sued for 'mismanagement' of state employee health plan*, REUTERS (Mar. 29, 2021), *available at* https://www.reuters.com/article/health-blue-cross/mass-blue-cross-sued-for-mismanagement-of-state-employee-health-plan-idUSL1N2LR2IC, last visited Oct. 20, 2022 (discussing litigation involving allegations of self-dealing).

annually.[6] A more recent report comes from the nonpartisan Council on Health Care Spending and Value, which opined that excess administrative costs wasted between $285 billion and $570 billion in healthcare spending in 2019 alone.[7]

7. The information reported in those articles and similar reports heightened Plaintiff's sensitivity to the risks potentially posed by the TPA managing Plaintiff's plan. Plaintiff therefore increased its efforts to assess Defendant's performance and to ensure Defendant honored its fiduciary duties to the Plan, participants, and beneficiaries.

III. DEFENDANT ACTIVELY FRUSTRATED PLAINTIFF'S ATTEMPTS TO ACCESS AND ANALYZE THE PLAN'S CLAIMS DATA.

8. In September 2021, Plaintiff requested its plan's claims data and information from Defendant in order to assess the plan's performance—both financially and the adequacy of care for Plaintiff's employees and their beneficiaries. What should have been a simple transfer of *the plan's* information from Defendant to Plaintiff—the plan sponsor, named fiduciary, and administrator—turned into a year-long trail of emails and other correspondence, littered with Defendant's excuses, arbitrary conditions, and illusory promises. Defendant would agree to provide the information and then renege, citing some obscure, inapplicable condition in its form agreement, which Defendant

[6] *AMA blasts insurers on 19.3 percent claims error rate*, HEALTHCARE IT NEWS (June 20, 2011), *available at* https://www.healthcareitnews.com/news/ama-blasts-insurers-193-percent-claims-error-rate, last visited Oct. 20, 2022.

[7] *The Role Of Administrative Waste In Excess US Health Spending*, HEALTH AFFAIRS (Oct. 6, 2022), *available at* https://www.healthaffairs.org/content/briefs/administrative-waste-excess-health-spending, last visited Oct. 20, 2022.

had carefully crafted in an effort to sidestep its fiduciary duties. Of course, to any extent Defendant's crafty contract provisions purport to relieve Defendant of its fiduciary responsibilities, ERISA invalidates those provisions.

9. Defendant even sought to impose new conditions restricting Plaintiff's access to information that were ungrounded in any contract language. Determined to obtain the plan's information, Plaintiff patiently endured this parade of promises, delays, obfuscation, and excuses. Plaintiff even attempted to satisfy some of Defendant's arbitrary, baseless conditions.

10. Following its year-long effort to obtain claims data belonging to the plan it sponsors and oversees, Plaintiff found itself still blocked by Defendant from critical information it needs to assess the plan's performance. As a result of Defendant's actions, Plaintiff remains unable to carry out its own fiduciary duties to the plan, plan participants, and beneficiaries as they relate to monitoring and assessing Defendant's claims management practices and performance of its fiduciary duties. Only after Defendant made clear it would not voluntarily provide the plan's information, Plaintiff filed this lawsuit.

IV. DESPITE THE SIMPLICITY OF THE ISSUES AND REQUESTED RELIEF, THIS CASE IS IMPORTANT TO PLAINTIFF AND SELF-FUNDED PLANS IN GENERAL.

11. Plaintiff merely seeks the plan's information that it has rightfully sought for well over a year. ERISA and, alternatively, applicable contract language entitles Plaintiff to analyze its own data.

12. This case presents two related questions for the Court, both of which have clear, common-sense answers supported by law and the relevant documents. The first is whether an ERISA healthcare plan's named fiduciary and administrator—who owes a statutory duty to exercise prudence in monitoring, engaging, and terminating TPAs—is entitled to analyze the plan's claims data in order to determine whether the plan's TPA has honored its own fiduciary duties. The answer is, of course, "yes."

13. The second question is whether the plan's TPA can interfere with the plan's named fiduciary and administrator's fiduciary role by withholding *the plan's* claims data based on the TPA's unilateral, erroneous assertion that the data is *the TPA's* "proprietary" and "confidential" information. The answer to this question is unequivocally "no."

14. Therefore, Plaintiff, on behalf of its plan, seeks an order compelling Defendant to produce the plan's claims data, which Plaintiff requested from Defendant more than a year ago. Plaintiffs' requested relief is modest. Nevertheless, because Defendant's and other TPAs' misconduct is so widespread, granting Plaintiff's request here will have important, widespread impacts on the protection of ERISA healthcare plans from opportunistic fiduciaries.

15. In the ERISA context, plan participants and beneficiaries bear the cost of fraud, waste, and abuse by plan fiduciaries who are unable or unwilling to prevent it. Congress has recently taken steps to address these risks. In the Consolidated Appropriations Act of 2021, Congress amended ERISA to clarify that employer-sponsored healthcare plans may obtain information relating to costs and quality of care,

regardless of restrictions in provider network contracts or whether TPAs might deem the information "proprietary."[8] As such, Congress recognized the importance of protecting the plan's right to review its own claims information.

16. Congress is not the only entity taking notice of TPAs' attempts to take advantage of self-funded plans and government healthcare funds. The Department of Labor and plan sponsors across the country are becoming more cognizant of the unfair and illegal conduct of TPAs and the threat that conduct poses for plans, their assets, and their participants and beneficiaries. And in a nearly symmetrical response, TPAs like Defendant have become more defensive.

17. At bottom, this case is about protecting Plaintiff from being forced to make decisions about its plan from a position of ignorance, a position imposed on Plaintiff by Defendant's obstinance and evasive misconduct. Under ERISA, managing healthcare spending and quality of care lies at the heart of a plan fiduciary's duties to a self-funded healthcare plan, plan participants, and beneficiaries. Those duties exist to ensure participants and beneficiaries receive a proper standard of healthcare and to protect contributions by plan participants and their employer. Thus, while Plaintiff merely seeks its plan's healthcare claims data, the impact of this case on the plan and the employees covered by it is potentially immense.[9]

[8] 29 U.S.C. § 1185m (emphasizing that plan sponsors are entitled to review data such as "provider-specific cost or quality of care information," "de-identified claims and encounter information," including "financial information, such as the allowed amount" and "any other data element included in claim or encounter transactions").

[9] While Plaintiff's plan has been harmed as set forth below, the extent of *pecuniary* harm is unknown and unknowable at this time given Defendant's misconduct at issue here. Plaintiff

PARTIES

18. Plaintiff Owens & Minor, Inc. is a Virginia corporation headquartered in Mechanicsville, Virginia. Plaintiff employs thousands of people in the United States. Plaintiff is the sponsor and named fiduciary for Plaintiff Owens & Minor Flexible Benefits Plan (**Plan**). The Plan is a welfare benefit plan under ERISA that provides healthcare coverage for Plaintiff's employees and their beneficiaries. The Plan is "self-funded," meaning that the Plan is primarily funded by contributions from Plaintiff Owens & Minor and Plan participants—employees of Owens & Minor.

19. Defendant Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield is a Virginia corporation and may be served through its registered agent, CT Corporation System, at 4701 Cox Rd., Ste. 285, Glen Allen, VA 23060-6808.

DEFENDANT'S CAMPAIGN OF DELAY AND OBFUSCATION FORCED PLAINTIFF TO SEEK JUDICIAL RELIEF

I. THE INFORMATION SOUGHT IS INTEGRAL TO PLAINTIFF'S DUTY TO ASSESS DEFENDANT'S PERFORMANCE OF ITS FIDUCIARY DUTIES TO THE PLAN.

20. As set forth below, *infra* paras. 58-89, Defendant owes fiduciary duties to the Plan commensurate with its fiduciary functions, which are likewise described below. As the Plan's named fiduciary, sponsor, and administrator, Plaintiff Owens & Minor must manage the Plan for the benefit of Plan participants and their beneficiaries. One of

therefore expressly reserves the right to pursue any losses caused to its plan and any damages suffered by the Plaintiff individually if it subsequently determines that any losses or damages have occurred.

Plaintiff's key duties is monitoring Defendant and its performance of administrative and fiduciary services that Plaintiff hired Defendant to perform.

21. An analysis of the Plan's claims information is essential to determining whether Defendant has properly managed the Plan's assets and provided adequate levels of care to participants and beneficiaries. Defendant has actively obstructed Plaintiff's attempts to perform that analysis by depriving Plaintiff of the information necessary to do so. In the process, Defendant has breached its own fiduciary duties under ERISA.

22. Plaintiff seeks the most comprehensive data layout and element sets internally available to Defendant related to Defendant's administration of medical and prescription claims for the Plan and its participants and beneficiaries. This includes without limitation billed and excluded charges, allowed charges, paid amounts, diagnosis codes, claim codes, and other categories of information and values.

23. The information Plaintiff seeks will allow it to properly assess a number of issues that bear on whether Defendant has upheld its duties to the Plan, Plan participants, and beneficiaries. Plaintiff owes a fiduciary duty to monitor Defendant and make prudent decisions regarding Defendant's retention or termination. No reasonable reading of ERISA supports the nonsensical—and unfair—conclusion that ERISA imposes a duty on Plaintiff to monitor Defendant but allows Defendant to conceal information necessary for that task.[10]

[10] *See* 29 U.S.C. § 1105(a), (c).

24. The data Plaintiff seeks is critical to adhering to its fiduciary duty by honoring its duty to monitor Defendant. For example, the information will demonstrate whether Defendant harmed the Plan by wasting assets; allowing conflicts of interest and the temptation of self-dealing to interfere with Defendant's judgment; engaging in negligent misconduct; or some combination thereof. And because this information provides the only means by which Plaintiff can analyze and assess Defendant's performance of its claims administration and other duties, it is necessary for Plaintiff to obtain this information in order to honor its own fiduciary duties to the Plan. In other words, the information and data sought provides the only avenue for Plaintiff to determine whether (i) claims were properly paid, (ii) the quality of care for participants and beneficiaries was sufficient, (iii) illegal conduct caused financial harm to the Plan, and (iv) Defendant has carried out its duties with the prudence and loyalty demanded by ERISA.

25. A reasonably prudent fiduciary in Defendant's position and under the same or similar circumstances would have agreed to produce the information at issue. The information is not "proprietary" to Defendant; it belongs to the Plan. Further, Defendant shares much of this information with competitors and brokers. And even if it were proprietary as Defendant claims, a reasonably prudent administrator would have still produced the information in light of the many protections of "proprietary" and "confidential" information under the relevant agreements.

26. Defendant, however, has demonstrated time and time again that it is not a reasonably prudent administrator and that its loyalties are severely misplaced.

II. DEFENDANT ACTIVELY INTERFERED WITH PLAINTIFF'S ATTEMPTS TO MONITOR AND ASSESS DEFENDANT'S PERFORMANCE.

27. Plaintiff, in its role as Plan sponsor and primary fiduciary, began its quest to obtain the Plan's claims information and data more than a year ago. What followed was Defendant's steady cadence of assurances followed by a pattern of obfuscation and delay.

28. On September 22, 2021, Plaintiff submitted its initial request for the Plan's information at issue here. Plaintiff emphasized it needed the information in order to evaluate the Plan's performance under Defendant's administration of the Plan. The request emphasized that Defendant's "standard reporting system" historically provided information with insufficient detail to adequately perform the evaluation. Plaintiff specifically requested "line item claim history detail from July 1, 2017 through and including the current year to date." Plaintiff also requested that Defendant retain "all records and data" until Plaintiff completed its analysis.

29. On September 22, 2021, Defendant responded by email: "I wanted to give you confidence that anything that is requested directly from your team will be fulfilled." However, over a year later Defendant *still* has not "fulfilled" any part of Plaintiff's request for medical claims information.[11] Rather, Defendant engaged in a conscious effort to avoid any oversight analyzing its responsibility for administering the Plan.

[11] With respect to the separate prescription information, Plaintiff has received only routine prescription data that is intentionally limited rendering it insufficient to perform a meaningful analysis.

30. On September 24, 2021, Plaintiff emphasized to Defendant that Plaintiff sought the "most comprehensive data layouts and elements that already exist internally" pertaining to the Plan.

31. On September 24, 2021, Defendant wrote Plaintiff. Despite Plaintiff's clear, unambiguous request for the most comprehensive set of data and information in Defendant's possession, Defendant represented it would "need a lot more detail" regarding the information sought.

32. On September 27, 2021, Plaintiff emphasized that it requested the claims information in order to fulfill its duties to the Plan: "We are doing this review as sponsor of the plan and consistent with our responsibility to the beneficiaries."

33. On September 28, 2021, Defendant represented to Plaintiff, "We're happy to get your data to you, we just need to work within our guidelines/policy for these requests. Sorry for the extra steps, [Defendant] is certainly not trying to be difficult or create unnecessary barriers with our policy." Little did Plaintiff know at the time, Defendant not only sought to "create unnecessary barriers"—it intended to unilaterally conjure new barriers in an effort to shirk its responsibility to the Plan.

34. On October 20, 2021, Defendant stated that it would transfer the data to Plaintiff: "[W]e'll need a [protected health information] release to indicate the data will come to [Plaintiff] and then you can share as you desire with downstream partners." Defendant added that there would be separate $1,000 charges for the prescription data and medical data.

35. On November 5, 2021, Plaintiff stated it would comply with the requests in Defendant's October 20, 2021 email.

36. On November 30, 2021, Plaintiff once again emphasized it sought "the most comprehensive data layout and element sets that are internally available," including at a minimum "every data element that you capture or produce regarding (1) eligibility detail; (2) claims detail; (3) provider detail; and (4) prior authorization detail." This request of course mirrored Plaintiff's prior requests, which were also attached to this email. Plaintiff added it would readily pay the $1,000 fee charged by Defendant for this production.

37. On February 21, 2022, Plaintiff sent an email in an effort to revisit the status of its request for data. Despite its previous unambiguous request for all information available, Plaintiff specified several data elements necessary for Plaintiff to conduct its analysis, including "billed," "allowed," and "paid" charges. This information is necessary for Plaintiff to determine whether Defendant has protected Plan assets, upheld its fiduciary duty to the Plan, and provided adequate levels of care for participants and beneficiaries.

38. On February 21, 2022, Defendant responded, "Out of the gate, I will say that we won't release both allowed and paid/billed. This would expose our confidential discounts/payment contracts aligned to each provider."

39. On March 3, 2022, Plaintiff responded that these components of information were necessary for Plaintiff's analysis. Defendant knew this. Plaintiff also expressed it "would consider a more specific [non-disclosure agreement] than the existing provisions in the agreement if it helps to be more specific than the existing language in place."

40. On March 18, 2022, responding to Plaintiff's request for an update, Defendant stated, "The report has been submitted to our extract team and has an [estimated completion date] of Tuesday, April 12th. Once the extract has been completed I will forward it over accordingly."

41. On March 29, 2022, Plaintiff requested that Defendant "provide a record layout and confirm the data format that will be provided" in order to prevent further delay and unnecessary work. Defendant responded that same day: "[We] are getting much closer to the data we will be allowed to share with [Plaintiff]." Defendant added that its data team executive advisor "is advising [Defendant] on what [its] availability of data sharing within our contractual confines with [Plaintiff] will be." Defendant's messaging was becoming increasingly vague and evasive.

42. After additional back-and-forth about minor matters, on April 7, 2022, Defendant provided the specifications for what it represented was "the most comprehensive set of data that [Defendant] is able to release." Remarkably, there was no additional context or explanation regarding the phrase "able to release." After careful review of the proposed production specifications, on April 25, 2022, Plaintiff identified glaring examples of highly relevant data points that Defendant both possessed but sought to conceal from Plaintiff. Those omissions included amount of billed charges, diagnoses, treatment codes, unique identifiers of patients, and the manner of claim adjudication. Plaintiff emphasized that "[t]his process is part of [Plaintiff's] effort to meet its responsibilities, and [Plaintiff] expects that [Defendant] would be working with, not against us. . . . [W]e have reached a point where we need to know unequivocally whether [Defendant] will provide [the

requested data].” After receiving no response to its continued request for data and Defendant’s rationale and legal basis for limiting any production, on May 11, 2022, Plaintiff followed up yet again. Defendant responded a day later that it would “follow-up with rationale and any detail asap.” Defendant still has not provided plausible “rationale” or any “detail” justifying its interference with Plaintiff’s attempt to honor its fiduciary duties to the Plan.

43. On or about July 19, 2022, in a letter to Defendant’s general counsel, Plaintiff voiced frustration in Defendant’s continued refusal to provide the Plan’s data and its continued interference with Plaintiff’s fiduciary duties. Plaintiff’s general counsel referenced eight previous attempts to obtain this information and emphasized that the data sought is “derived from [Plaintiff’s] health plans” and that Defendant “is in possession of [Plaintiff’s] data only because it serves as [Plaintiff’s] administrative services organization and ERISA fiduciary for those plans.” Plaintiff’s general counsel cited Defendant’s omission of “large and essential data elements,” which are “critical for any meaningful plan review or oversight.” Finally, Plaintiff provided Defendant a detailed, non-exhaustive list of data that Plaintiff correctly anticipated would be in “the universe of [the Plan’s] medical data” maintained by Defendant on the Plan’s behalf.

44. Defendant responded on July 25, 2022, with further delay and obfuscation and with vague, baseless references to an inability to produce “proprietary” data belonging to the Plan:

> . . . . We have met internally with legal, privacy and our data use teams and want to provide the most inclusive set of data that Owens and Minor requests

> and you outline in the attached letter. Before we share data, we need to fully understand the Business Use Case for this set of data. We are requesting a meeting with you/your team to review these items in detail. [Defendant] will supply data per our Data Use & Enabling Policy[12] and according to our ASO Agreement with [Plaintiff].[13] We will be unable to supply some components of the request, which are either unreportable, proprietary or would compromise competitive details of other providers contracted with [Defendant]. (footnotes added).

45. In its July 28, 2022 response, Plaintiff voiced its continued frustration in Defendant's ten-month campaign to interfere with and delay Plaintiff's attempt to honor its fiduciary duties to Plan participants and beneficiaries. Plaintiff outlined its many attempts to access the Plan's data and reminded Defendant that production and analysis of a complete data set was necessary for *both* parties to satisfy their fiduciary duties. Again, Defendant knew this.

46. On July 28, 2022, Defendant responded by letter: "It is [Defendant's] desire to share as much data as we are legally allowed to share with your organization." This is perplexing because Defendant is *legally* allowed to share *all* requested Plan data. Indeed, it is required to. Defendant simply elected not to. Then, the letter vaguely stated that

[12] There is no evidence Plaintiff agreed to this policy. And to the extent this policy attempts to relieve Defendant of its fiduciary duties under ERISA, it is void. 29 U.S.C. § 1110(a) ("[With inapplicable exceptions], any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy.").

[13] This agreement, the Administrative Services Agreement, is discussed in detail below.

"Proprietary & Confidential Information" would not be included in the data production, nor would "BlueCard data" and "DME data for non-Owens & Minor owned entities." It added, "we are unable to share some of your requested detail due to competitive concerns as well as not having a data sharing agreement stating valid and approved use cases in place with your organization."

47. On July 30, 2022, responding to Defendant's vague, baseless reference to unproducible "proprietary" and "confidential" data in its data extract proposal, Plaintiff asks, "Please provide us with a clear and specific description of each category of information or data that you contend is proprietary or confidential."

48. On August 1, 2022, Defendant—nearly a year after Plaintiff requested that it retain all plan data pending Plaintiff's analysis—notified Plaintiff for the first time in this year-long saga that "our reporting system is limited to 36 months of data." Defendant did not state one way or another whether it had destroyed data more than three years old. But given that ERISA's default limitations period is six years for fiduciary claims, it is certainly unreasonable to destroy records of claims information from that six-year timeframe. In that same correspondence, Defendant once again refused to "provide billed, allowed and excluded charges" based on a vague and inaccurate characterization of that information as "proprietary & confidential." Plaintiff responded the same day by emphasizing yet again that the information withheld by Defendant "is what we need to ensure compliance with the [Administrative Services Agreement detailed below] and fulfillment of fiduciary duties."

49. On August 8, 2022, Plaintiff's counsel sent Defendant a notice of representation, once again asking for the Plan's data and reiterating the August 19, 2022 deadline for complying with this request.

50. On August 18, 2022, Plaintiff's counsel emailed Defendant as a follow-up to a phone conference two days before. Plaintiff's counsel expressed concern regarding Defendant's representation—for the first time in the year-long process—that "a key impediment to the production of data has been one or more Blue Cross Blue Shield National Association (BCBSNA) policies." Plaintiff requested further information regarding how BCBSNA policies bind Plaintiff and prevent Plaintiff from accessing data for its own Plan. As of the filing of this Complaint, Defendant has refused to provide this information.

51. Also on August 18, 2022, Defendant emailed Plaintiff, disingenuously expressing concern about the involvement of Plaintiffs' counsel in the data review: "If the data were to be shared directly with [Plaintiff], we do not have to take these additional steps," such as execution of a confidentiality agreement by Plaintiff's counsel. But if that were so, why had Defendant not provided the information following one of the numerous requests by Plaintiff directly in the previous eleven months? Defendant went on to state, "we will continue to exclude DME claims for services outside of Owens and Minor, but agree to include the following data elements," which included allowed charges, billed charges, excluded charges, and BlueCard data related to claims detail requested in non-Anthem states. Despite this assurance, Defendant has withheld the information in direct contravention of its duty to the Plan.

52. On August 19, 2022, Plaintiff reiterated its agreement to preserve the confidentiality of any protected information. Plaintiff also asked that Defendant confirm the specific data that Defendant would share and any data that Defendant would withhold. Finally, Plaintiff requested that the BCBSNA policies—which allegedly limit Plaintiff's access to its own Plan's information—be provided for review.

53. On August 22, 2022, Defendant sent to Plaintiff's counsel "excerpted and relevant Blue Card Policies" that Defendant previously represented prevented production of Plaintiff's Plan data. But even assuming those policies bound Plaintiff—which is not true—the policies contained explicit exceptions that did not restrict production "to the extent the disclosure is necessary to comply with a legal requirement" and "when such access, use or transfer does not violate applicable state and/or federal law." As set forth below, the information sought is necessary for Plaintiff and Defendant to comply with legal requirements under ERISA and other governing law and agreements. Defendant also represented that it would produce the information once a new confidentiality agreement was signed.

54. On August 24, 2022, Plaintiff's counsel renewed its request for any evidence that BCBSNA's restrictions on production of data are binding on Plaintiff or the Plan.

55. On August 31, 2022, nearly a year after Plaintiff commenced these efforts, Defendant emailed its "standard confidentiality agreement" and conditioned production of *Plaintiff's* information on execution of this document. If any doubts remained regarding the veracity of Defendant's promise to cooperate, its purported "standard" confidentiality agreement conclusively demonstrated the falsity of that promise. In truth, Defendant's

"standard" confidentiality agreement represented a further attempt by Defendant to avoid assessment of its administration of the Plan. The confidentiality agreement, to which neither Plaintiff nor any representative of Plaintiff ever agreed, made clear that any agreement by Defendant to produce the Plan's information was illusory:

> **Disclaimer and Exculpation**. [Defendant] provides the Information on an "as-is" basis, and makes no representation or warranty as to the accuracy or reliability of any conclusions or interpretations made by Plans and/or [Plaintiff] on the basis of the Information. [Plaintiff] releases [Defendant] and its agents and employees from any and all liability whatsoever for any erroneous, inaccurate, or incomplete Information.[14] (footnote added).

This provision rendered illusory any promise by Defendant to finally provide the information that Plaintiff requires to fulfill its fiduciary duties to Plan participants and beneficiaries.

56. Exhausted from the year-long, unsuccessful campaign to extricate the Plan's data from Defendant—and spurned by Defendant's empty assurances and vague references to unproducible "proprietary" data—Plaintiff submitted a letter to Defendant alerting it of Plaintiff's intent to seek judicial relief.

---

[14] According to its September 26, 2022 email, Defendant purportedly "included the Exculpation and Disclaimer provision for several reasons, including [Plaintiff's] own protection." It remains unclear how Plaintiff would be "protected" by shirking its fiduciary responsibilities and agreeing to assess the Plan's performance based on inaccurate, incomplete, or erroneous data.

In a follow-up attempt to justify its decision to hold Plan data hostage and its "Disclaimer and Exculpation" provision, Defendant cited vague, hypothetical reasons and ASA articles 10 and 11. None of these excuses justifies Defendant's misconduct.

57. Having exhausted all reasonable efforts to uphold its fiduciary duties and to confirm whether Defendant has satisfied its fiduciary duties with respect to Plan funds and quality of care, Plaintiff filed this Complaint.

THE SIGNIFICANCE OF THE ADMINISTRATIVE SERVICES AGREEMENT AND THE PARTIES' RESPECTIVE CONDUCT

I. THE ADMINISTRATIVE SERVICES AGREEMENT GENERALLY

58. Defendant's cascade of excuses centered on the parties' Administrative Services Agreement (**ASA**), which Defendant frequently and incorrectly cited as imposing restrictions or conditions on Plaintiff's ability to analyze its own information. Defendant's reliance on the ASA is misplaced. *First*, the ASA conclusively establishes that Defendant is a fiduciary under ERISA. *Second*, even if Defendant's wily drafting of the ASA actually purports to relieve Defendant of its fiduciary duties, ERISA nullifies any such provisions. *Third*, the ASA facially demonstrates that, consistent with its rights and duties under ERISA, Plaintiff is entitled to access and analyze its own claims information.

59. Plaintiff required the services of a third-party administrator (**TPA**) to administer the Plan. Plaintiff is not a claims administrator; nor does Plaintiff have the expertise, personnel, or systems necessary to administer the Plan's claims. Plaintiff therefore engaged Defendant as the Plan's TPA and executed the ASA, delegating much of Plaintiff's fiduciary responsibilities under the Plan to Defendant. Defendant knew Plaintiff lacked the ability to serve as the Plan's claims administrator, and Defendant knew that Plaintiff relied on Defendant's assurances regarding its services.

60. The ASA became effective on June 1, 2017. **Ex. A** at 1. The parties acknowledged that Plaintiff "is the sponsor of a self-funded Group Health Plan . . . providing . . . health care benefits to certain eligible employees and their qualified dependents." *Id.* The parties agreed that Defendant would "administer certain elements of [Plaintiff's] Group Health Plan." *Id.* The ASA also identified the Plan as an ERISA plan. *Id.*

61. Plaintiff has complied with all aspects of the ASA and other agreements that comprise the ASA and govern the relationships among the Plan, Plaintiff Owens & Minor, and Defendant.

62. The ASA defines "billed charges" as "[t]he amount that appears on a Member's Claim form (or other written notification acceptable to [Defendant] that Covered Services have been provided) as the Provider's charge for the services rendered to a Member, without any adjustment or reduction and irrespective of any applicable reimbursement arrangement with the Provider." **Ex. A** at 1. "Allowed amounts" generally refers to amounts that Defendant deems payable by the Plan on particular healthcare claims. Other important values are the sums paid by the Plan and sums paid to providers. These values, along with other data and information, reveal critical information bearing on how the Plan's assets are utilized and whether participants and beneficiaries receive adequate levels of care.

63. The ASA defines *Plaintiff's* "proprietary information and confidential information" as including "information about the systems, procedures, methodologies and practices used by [Plaintiff] to run . . . the Plan." **Ex. A** at 3.

64. The ASA contemplated the sharing of "confidential" and "proprietary" information between Plaintiff and Defendant for the purpose of managing the Plan. *See generally* **Ex. A** at 9-10, art. 10. While the ASA reasonably required the parties to safeguard each other's confidential information,[15] it expressly allows Plaintiff to "use or disclose" Defendant's proprietary information for the purpose of "administering the Plan." *Id.* at 9 art. 10.c. The ASA further acknowledges that "use or disclosure" of proprietary information may be called for "pursuant to law." *Id.* at 9-10 art. 10.f. And with respect to data extracts and reports specifically at issue here, even if Plaintiff designates a third party to review Plan information that contains Defendant's purported proprietary information, the ASA merely requires that third party to comply with ASA article 10 and to "enter into a confidentiality agreement with [Defendant]." **Ex. A** at 10, art. 11.b. Thus, the ASA plainly and expressly grants Plaintiff and its designees access to the Plan's data—even if Defendant deems it "proprietary"—in order to administer the Plan and carry out fiduciary duties owed under ERISA and applicable agreements.

II. THE PARTIES ARE ERISA FIDUCIARIES.

65. Defendant and Plaintiff Owens & Minor are both Plan fiduciaries. Plaintiff Owens & Minor is a named fiduciary and the Plan's sponsor and administrator. Defendant is a functional fiduciary and has expressly assumed fiduciary duties to the Plan at issue here.

[15] Note, however, that nothing in the ASA's provisions calling for protection of proprietary information contemplated that Plaintiff must accept information "as-is" regardless of its completeness or accuracy. That did not stop Defendant from demanding such an agreement in the correspondence detailed above.

66. ERISA fiduciaries are either "named" or "functional." A named fiduciary "means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly." 29 U.S.C. § 1102(a)(2). There are three general categories of functional fiduciaries defined by ERISA:

> [A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan *or* exercises any authority or control respecting management or disposition of its assets,
>
> (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, *or* has any authority or responsibility to do so, *or*
>
> (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated [as fiduciary] under section 1105(c)(1)(B) of this title.

29 U.S.C. § 1002(21)(A) (emphasis added). Defendant is a "fiduciary" under one or more of these definitions.

A. By Virtue of Its Role as the Plan's TPA, Defendant Possessed and Exercised Control Over Plan Assets and Over Plan Administration and Management.

67. As noted above, the Plan is self-funded. Thus, the Plan assets represent contributions by Plaintiff Owens & Minor, its employees, and former employees. Those contributions benefit the Plan, Plan participants, and beneficiaries by paying healthcare claims for participants and beneficiaries. Plaintiff expresses to participants and beneficiaries that Plaintiff Owens & Minor's and participants' contributions secure the healthcare benefits promised to them by Plaintiff. The amount of contributions is based in large part on actual Plan costs and expenditures each year. This is a common-sense proposition given that the Plan directly pays for healthcare claims, which Defendant administered for the Plan. Defendant assumed a fiduciary role by accepting and exercising authority, control, and discretion over plan management and assets.

68. The ASA expressly names Defendant as a plan fiduciary with respect to key functions of the Plan and identifies Defendant as a functional fiduciary with respect to other actions:

> Pursuant to Section 405(c)(1) of ERISA, *[Plaintiff] delegates to [Defendant] fiduciary authority to determine claims for benefits under the Plan* as well as the authority to act as the appropriate fiduciary under Section 503 of ERISA to determine appeals of any adverse benefit determinations under the Plan. [Defendant] shall administer complaints, appeals and requests for independent review according to [Defendant's] complaint and appeals policy, and any applicable law or regulation, unless otherwise provided in

> the Benefits Booklet. In carrying out this authority, *[Defendant] is delegated full discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan*. [Defendant] shall be deemed to have properly exercised such authority unless a Member proves that [Defendant] has abused its discretion or that its decision is arbitrary and capricious. [Defendant] is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement and only to the extent that its performance of such actions constitutes fiduciary action under ERISA.

Ex. A at 4, art. 2.c (emphasis added).

69. The ASA assigned Defendant the duty and right to process claims and "to determine the amount" that "is due and payable" according to *Defendant's* "medical policies and medical policy exception process, its definition of medical necessity, [and] its precertification and/or preauthorization policies." **Ex. A** at 3, art. 2.b (emphasis added). Thus, Defendant possessed authority—which it exercised during all relevant times—to unilaterally commit Plan funds to pay healthcare claims.

70. Defendant enjoyed discretion with respect to "[t]he amount charged" against the Plan. **Ex. A** at 2 ("PAID CLAIM"). For instance, the ASA purports to grant Defendant discretion to pay a vender more than actual billed charges for a particular service or supply. *Id.* § 1. It permitted Defendant to decide the reimbursement methodology for claims without express regard to cost. *Id.* And it required the Plan to pay Defendant for claims "without regard . . . to whether such payments are increased or decreased by the . . .

achievement of, or failure to achieve, certain specified goals, outcomes or standards *adopted by [Defendant]*." *Id.* (emphasis added).

71. Defendant exercised extensive control, authority, and discretion over the Plan and its assets through Defendant's contractual arrangements with providers. Both in practice and under the ASA, Defendant exercised absolute control over reimbursement arrangements with providers, which directly impacted both the amounts paid by the Plan and the quality of healthcare provided under the Plan. *See, e.g.*, **Ex. A** at 5, art. 2.s. ("[Defendant] shall have the authority, in its sole discretion, to build and maintain its Provider network on its own behalf. . . . [Defendant] shall be solely responsible for . . . negotiating rates with Providers or auditing Providers. . . ."), art. 2.o (Defendant's contracts with providers, as Defendant may amend them from time to time, will be used to administer and price claims). This control also extends to pharmaceutical benefits paid with Plan assets. *See, e.g.*, **Ex. A** at 12, art. 14.a.1 ("[Defendant] shall determine, in its sole discretion, which pharmacies shall be Network Pharmacies, and the composition of Network Pharmacies may change from time to time."); art. 14.a.2 (Plan "shall" adopt the formulary that governs, among other things, the amount the Plan pays for prescription drugs).

72. Defendant also enjoyed control and discretion over sums it retained from the difference of amounts paid by the Plan for prescription drugs and the amount actually invoiced for prescription drugs. **Ex. A** at 2, § 2.

73. Defendant enjoyed discretion and control with respect to settling claims and other disputes that would then be charged against the Plan. **Ex. A** at 2, § 5.

74. Defendant's control over Plan assets is extensive. Defendant, based on its control and discretion described above, unilaterally determines the amounts to be paid by the Plan for healthcare claims. *See, e.g.*, **Ex. A** at 2-3 ("PAID CLAIM"). Under the ASA, Defendant is authorized to take control of Plan monies and apply them to amounts Defendant determines are due. Under the ASA, the Plan must pay those sums, which are not subject to dispute by Plaintiff, on a weekly basis, and the ASA authorizes Defendant to take that money from the Plan through an automated clearing house (ACH) "pull": "Anthem will initiate an ACH demand debit transaction that will withdraw the amount due from a designated Employer bank account no later than three (3) business days following the Invoice Due Date." **Ex. A** at 21-22, schedule A § 4.

75. Other documents mirror these ASA provisions:

> [Defendant] shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, *to determine all questions arising under the Plan*, to resolve Member appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. [Defendant] has complete discretion to interpret the Benefit Booklet. *The Claims*

> *Administrator's*[16] *determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount*." **Ex. B**, 2020 SPD at 84. (emphasis and footnote added).[17]

76. The SPD describes the "maximum amount of reimbursement *[Defendant]* will allow for services and supplies" and refers to Defendant's determination of the maximum allowed reimbursement for particular services. **Ex. B**, 2020 SPD at 62-63 (emphasis added).

77. With respect to out-of-network claims, Defendant acknowledged that it established, "at its[] discretion," the fee schedule/rate for those services. **Ex. B**, 2020 SPD at 63.

78. The Plan documents make clear that all monies committed by Defendant to fund claims belong to the Plan. For instance, Defendant has repeatedly disclaimed any obligation for payment of claims and concedes that monies Defendant applies to pay claims belong to the Plan. *See* **Ex. B**, 2020 SPD at 2, 93. Indeed, Defendant represents that it "does not assume any financial risk or obligation with respect to claims." **Ex. B**, 2020 SPD at 93.

[16] "Claims administrator" refers to Defendant Anthem. **Ex. B**, 2020 SPD at 93.

[17] "SPD" refers to Summary Plan Description or the Medical Benefit Booklet attached as exhibit B.

The Plan assumed all financial risk while Defendant retained control and discretion to administer the Plan and allocate its assets.

B. DEFENDANT'S DISCRETION AND CONTROL EXTENDED TO RECOVERY OF MONIES ERRONEOUSLY PAID BY THE PLAN OR OTHERWISE OWED TO THE PLAN.

79. Defendant's control, authority, and discretion over Plan management, administration, and assets extended beyond the value it allowed and paid on claims in the first instance. With respect to Defendant's authority to pursue recovery of sums caused by its overpayment of claims, Defendant "shall determine which recoveries it will pursue, and in no event will [Defendant] pursue a recovery if it reasonably believes that the cost of the collection is likely to exceed the recovery amount or if the recovery is prohibited by law or an agreement with a Provider or Vendor." **Ex. A** at 11, art. 13.e. With respect to overpayment discovered in Plan-initiated audits, "[a]ny errors identified as the result of the audit shall be subject to [Defendant's] review and acceptance prior to initiating any recoveries of Paid Claims." **Ex. A** at 10, art. 12.d.[18]

80. Defendant's extensive control and discretion with respect to audits likewise evidences control and authority over Plan assets. As alleged above, even if an audit shows that claims were improperly paid, the Plan can make no recovery of its assets without "[Defendant's] review and acceptance" of the audit results. **Ex. A** at 10, art. 12.d. The ASA purports to grant Defendant extensive control over the audit process, including selection of the auditor and parameters of the audit. *See generally* **Ex. A** art. 12. To the extent Defendant

[18] Similarly, "settlements of reimbursement disputes brought by Providers do not require the approval of [Plaintiff]." **Ex. A** at 13, art. 16.e.

recovers Plan monies through its own audit, it exercises extensive control over whether to even pursue recoveries and over the amount of those recovered monies that return to the Plan. *See* **Ex. A** arts. 13.d-e.

81. Further, "[Defendant] may, but is not required to, readjudicate Claims or adjust [Plan participants' and beneficiaries'] cost share payments related to the recoveries made from a Provider or a Vendor." **Ex. A** at 11, art. 13.e.

C. DEFENDANT EXERCISED EXTENSIVE CONTROL AND DISCRETION OVER PLAN DATA AND INFORMATION AT ISSUE IN THIS CASE.

82. Tightly tethered to Plaintiff's claims is Defendant's purported control and discretion over Plan information. **Ex. A** at 10, art. 11.a. (purporting to grant discretion to Defendant to "approve" release of Plan information not in Defendant's "standard account reporting package."). Defendant sought to retain discretion over the "types, format, content and purpose" of the information requested. *Id.*

83. Defendant attempted to retain discretion and control over whether to permit Plaintiff to utilize a third party to review Plan data and information. *See* **Ex. A** at 10, art. 11.b.

84. Among the information and data at issue in this lawsuit is Plan claims data that Defendant has mischaracterized as Defendant's "proprietary" or "confidential" information. The ASA purports to provide Defendant "unlimited rights to use" information and data *properly* designated as such. **Ex. A** at 10, art. 11.d. And even with respect to "other Claim-related data collected in [Defendant's] performance of services under [the ASA,]" Defendant exercised control and discretion over the use of that information as well. *Id.*

85. The ASA further purports to allow Defendant to provide claims-related information to third parties "for a variety of lawful purposes including . . . research, monitoring, benchmarking and analysis of industry and health care trends." **Ex. A** at 10, art. 11.d.

86. The ASA nevertheless acknowledges that Plaintiff is entitled to utilize Defendant's "confidential" information while purporting to grant Defendant further discretion over Plan information and data: "[Defendant] reserves the right to terminate any audit being performed by or for [Plaintiff] if [Defendant] determines that the confidentiality of its information is not properly being maintained . . . ." **Ex.** A at 10-11, art. 12.d.

87. With respect to authority, discretion, and control that the ASA purportedly grants Defendant with respect to Plan monies and the Plan's information, Defendant has exercised that authority, discretion, and control.

88. Defendant's conduct over the past year has demonstrated that, with respect to Plan information and data, Defendant exercises authority and discretion over the management and administration of the Plan and its information. Defendant's position that it has authority to conceal claims data at issue here lacks any support under ERISA. Nevertheless, Defendant has represented that it can unilaterally decide to produce the information sought or limit the Plan's access to that information. And the precise question presented to the Court is whether Defendant breached its duties to the Plan by refusing to provide the Plan's claims data so that Plaintiff could adequately assess Defendant's performance of duties owed to the Plan, Plan participants, and beneficiaries.

D. PLAINTIFF OWENS & MINOR IS THE PLAN SPONSOR AND A FIDUCIARY WITH STANDING TO PROSECUTE ERISA CLAIMS ON THE PLAN'S BEHALF.

89. The ASA identifies Plaintiff as the Plan sponsor, named fiduciary, and as the party with primary discretion and authority over all aspects of the Plan. **Ex. A** at 1 and 7, art. 3.b. (acknowledging that "[Plaintiff] retains all final authority and responsibility for the Plan," which would necessarily include Plan information at issue here).

90. Indeed, as the sponsor and named fiduciary of the Plan, Plaintiff is afforded discretion and control over Plan assets and management of the Plan. Plaintiff's fiduciary role extends to exercising discretion over and management of TPAs such as Defendant. Relevant here is Plaintiff's authority under the Plan—and its duty to the Plan and Plan beneficiaries and participants—to engage and monitor TPAs and their use of Plan assets and information.

91. For well over a year—and now through this Complaint—Plaintiff has sought information that is integral to determining whether Defendant, the Plan's TPA, properly administered the Plan and paid healthcare claims according to its duties under ERISA, the ASA, and other Plan documents. Stated another way, Plaintiff requires the relevant information in order to ensure that Defendant is discharging its duties with the requisite prudence and "solely in the interest of the participants and beneficiaries and (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." *See* 29 U.S.C. §§ 1104(a)(1), 1105(a) and (c). This task lies at the heart of Plaintiff's authority and duty as the Plan sponsor, administrator, and named fiduciary.

JURISDICTION AND VENUE

92. This is a fiduciary action brought by a plan fiduciary pursuant to ERISA. Thus, United States district courts enjoy subject matter jurisdiction over this dispute. 29 U.S.C. § 1132(e)(1); *see also* 28 U.S.C. § 1331 (federal question); *id.* § 1367 (supplemental jurisdiction).

93. Venue is proper in this district and division because the Plan is administered in Richmond, Virginia, the relevant breaches occurred in Richmond, Virginia, and Defendant is headquartered in Richmond, Virginia. 29 U.S.C. § 1132(e)(2); 28 U.S.C. § 1391(b); E.D. Va. Loc. Civ. R. 3(B)(4). Those same grounds support this Court's exercise of personal jurisdiction over Defendant. Moreover, this case arises from Defendant's misconduct in Virginia; from an agreement or agreements negotiated, executed, and performable in Virginia and that designate Virginia law as governing state law; and from Defendant's contacts in Virginia which are described throughout this Complaint.

CAUSE OF ACTION FOR ERISA VIOLATIONS

94. Plaintiff incorporates all other paragraphs in this Complaint as if fully restated here.

95. Under ERISA, Defendant is a Plan fiduciary.

96. The Plan is an ERISA welfare benefit plan subject to the protections afforded by ERISA.

97. Plaintiff Owens & Minor is a Plan fiduciary and the Plan's sponsor. Plaintiff Owens & Minor brings this claim on the Plan's behalf in Plaintiff's capacity as Plan sponsor and named fiduciary.

98. Under ERISA, Defendant must discharge its duties to the Plan solely in the interest of Plan participants and beneficiaries and "for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and defraying reasonable expenses of administering the plan." *See* 29 U.S.C § 1104(a)(1). ERISA requires Defendant to discharge its duties with the "care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims . . . and in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [ERISA]." *Id.* § 1104(a)(2).

99. Defendant violated its duties under ERISA by refusing to cooperate with Plaintiff's attempt to properly analyze claims data for the purpose of, among other things, ensuring the proper use of Plan assets and assessing the quality of care provided to Plan participants and beneficiaries. A reasonably prudent administrator in Defendant's position—actually discharging its duties in the sole interest of Plan participants and beneficiaries—would readily cooperate with Plaintiff's efforts. But an imprudent administrator—or one attempting to conceal its misconduct—would do exactly what Defendant has done here.

100. Defendant also violated these duties when it misappropriated and concealed the Plan's claims information by unilaterally, arbitrarily, and erroneously deeming it "proprietary" in order to prevent the Plan from accessing its information. A reasonably prudent administrator would not refuse to provide the claims data sought, especially given

Plaintiff's agreement to protect information to any extent it actually contains Defendant's "proprietary" information.

101. Defendant also violated these duties by placing its own desire to conceal the information over the interests of the Plan, plan participants, and beneficiaries. On information and belief, Defendant seeks to conceal its mismanagement of fund assets, to conceal self-dealing, to prevent Plaintiff from monitoring Defendant's performance, or some other self-interested purpose. No matter the motive, Defendant's loyalty was and remains unlawfully divided.

102. Defendant also violated these duties by failing to inform Plaintiff that it would withhold and exclude vital claims information from any production of information to Plaintiff Owens & Minor in its capacity as Plan sponsor and named fiduciary. A reasonably prudent claims administrator would know that the information Plaintiff seeks is critical to analyzing claims data and assessing a claims administrator's performance. And a reasonably prudent claims administrator would know that, in engaging and monitoring a claims administrator, a plan fiduciary and sponsor in Plaintiff Owens & Minor's position would need to know whether Defendant would subsequently refuse to share it. As a fiduciary with a duty to monitor TPAs, Plaintiff would not have engaged Defendant's services had Defendant disclosed that it would unilaterally deem *the Plan's data* unproducible based on a faulty and fraudulent claim that the data belonged to Defendant and was "proprietary" in nature.

103. Defendant has harmed Plaintiff by preventing it from conducting a proper analysis of Defendant's claims administration services in order to ensure the preservation

of Plan assets and to assess quality of care. Plaintiff cannot perform a proper analysis without the information and data sought by this lawsuit. Without a proper analysis of the information Plaintiff seeks, the Plan is forced in the untenable position of choosing one of the following options without all the available information: (i) sue Defendant for return of losses caused by its mismanagement given the reasonable inferences supported by Defendant's suspicious concealment of the information and data; (ii) engage a new claims administrator without a full understanding of whether the Plan would benefit from that change; or (iii) allow Defendant to continue administering claims for the Plan and assume the risk that Defendant is mismanaging or misappropriating Plan funds or failing to provide adequate quality of care to participants and beneficiaries.

104. To any extent sufficient analysis is possible without the outstanding information and data, which Plaintiff denies, it will create much more expense to the Plan and require significant guesswork which will harm the Plan further.

105. Plaintiff has also been harmed because Defendant's misconduct would interfere with certain disclosure requirements under ERISA. *See, e.g.*, 29 U.S.C. § 1024(b)(4).

106. Further, the Plan's claims data and information have value and, therefore, constitute "assets." Specifically, the claims information will reveal whether the Plan is operating satisfactorily and whether the Plan could save money or operate more efficiently. The claims data may also reveal whether the Plan is entitled to recoup monies lost due to a breach of fiduciary duty by Defendant or due to conduct by third parties like providers and

vendors. It should be undisputed that this information and data are assets that belong to the Plan.

107. ERISA prohibits a fiduciary from dealing with assets of the plan in the fiduciary's "own interest or for [its] account." 29 U.S.C. § 1106(b). By strategically *mis*characterizing the Plan's claims information as *Defendant's* "confidential" and "proprietary" information—and by refusing to produce relevant claims data out of fear that its fiduciary breaches will come to light or that the data reveals Defendant's performance was otherwise unsatisfactory—Defendant is unlawfully dealing with this informational asset for its own interest and for its own account.

108. To remedy these violations, Plaintiff seeks an order requiring Defendant to produce all data and claims information previously requested by Plaintiff. *See supra* paras. 22, 28, 30, 36, 37, 42.

109. Plaintiff also seeks declaratory judgment under ERISA and 28 U.S.C. § 2201. Specifically, Plaintiff seeks a declaration that, under ERISA and/or the applicable agreements, Plaintiff is entitled to the Plan information it has requested from Defendant.

110. Plaintiff seeks a declaration that the requested information and data does not constitute Defendant's "proprietary" and "confidential" information."

111. Plaintiff seeks a declaration that, to the extent the ASA or any other agreement or document purports to permit Defendant to block Plaintiff's access to Plan claims information, it is void under ERISA.

112. Finally, Plaintiff seeks a declaration that Defendant is required to produce the requested information to Plaintiff without demanding any restriction other than restrictions both allowed by ERISA and to which Plaintiff has expressly agreed.

STATE LAW CAUSES OF ACTION

113. To the extent ERISA does not have preemptive effect on relevant state law claims, Plaintiff alleges the following state law causes of action.

I. BREACH OF CONTRACT UNDER VIRGINIA LAW

114. Plaintiff incorporates all other paragraphs in this Complaint as if fully restated here.

115. Plaintiff further incorporates the ASA, attached as exhibit A, as if fully restated here.

116. This claim is brought by Plaintiff Owens & Minor in its individual capacity and, alternatively, on behalf of the Plan.

117. Plaintiff and Defendant are parties to the ASA.

118. The ASA states, "Nothing in this Agreement shall impair or limit a Party's right to use and disclose its Information for its own lawful business purposes." The ASA also states that each party retains ownership of its own information. Further, even assuming the information at issue contains Defendant's "proprietary" information, the ASA expressly allows Plaintiff to "use or disclose" Defendant's proprietary information for the purpose of "administering the Plan." Defendant breached these provisions by purporting to take ownership of information owned by Plaintiff Owens & Minor individually or, alternatively, by the Plan. Defendant further breached these provisions by impairing

Plaintiff's right to use its information for its own lawful business purposes—*i.e.* confirming that the Plan has been properly administered and managed by Defendant.

119. As a result of Defendant's breaches, Plaintiff has suffered harm as set forth above.

II. BREACH OF GOOD FAITH AND FAIR DEALING UNDER VIRGINIA LAW

120. Plaintiff incorporates all other allegations in this Complaint as if fully restated here.

121. This claim is brought by Plaintiff Owens & Minor in its individual capacity and, alternatively, on behalf of the Plan.

122. Every agreement carries with it an implied duty of good faith and fair dealing. This implied duty applies even when a written contract provides the defendant discretion to perform a particular act.

123. As set forth above, the ASA assigned Defendant certain levels of control over Plan information. However, neither the ASA nor any other agreement grants Defendant the discretion to deem Plan claims data the "proprietary" or "confidential" information of Defendant. And no agreement grants Defendant discretion to withhold from Plaintiff information belonging to the Plan. Defendant's refusal to provide Plaintiff its Plan's claims data, even if not expressly prohibited by the governing contracts, represents bad faith and evinces a desire by Defendant to evade accountability and deny Plaintiff the bargained-for benefit of the ASA.

124. To the extent the ASA granted Defendant discretion or control over the information sought by Plaintiff, Defendant has exercised that discretion or control

dishonestly, resulting in its refusal to produce the Plan's information and data. First, Defendant intentionally mischaracterized the information and data as Defendant's "proprietary" or "confidential" information belonging to Defendant in order to justify Defendant's concealment of that information. Second, Defendant agreed to voluntarily produce that information only if Plaintiff agreed to accept the information "as-is," even if it is incomplete, inaccurate, and erroneous. Third, on information and belief, Defendant refused to produce the requested information and data in an effort to conceal its mismanagement of Plan funds and other wrongdoing against the Plan or Plaintiff Owens & Minor.

125. As a result of Defendant's breach of its implied duty of good faith and fair dealing, Plaintiff has suffered harm as set forth above.

III. BREACH OF FIDUCIARY DUTY UNDER VIRGINIA LAW

126. Plaintiff incorporates all other allegations in this Complaint as if fully restated here.

127. This claim is brought by Plaintiff Owens & Minor in its individual capacity and, alternatively, on behalf of the Plan.

128. Plaintiff placed—and Defendant invited and accepted—trust and confidence in Defendant. Indeed, Plaintiff assigned significant discretion to Defendant to spend Plan monies comprised of contributions by Plaintiff Owens & Minor and its employees.

129. Given this relationship of trust and confidence, Defendant owes a duty of full disclosure to Plaintiff in its individual and representative capacities relating to Defendant's use of Plan assets. That duty extends without limitation to disclosing billed and excluded

charges, allowed charges, paid amounts, diagnosis codes, claim codes, and other categories of information and values.

130. Defendant breached its fiduciary duties by concealing and withholding Plan data from Plaintiff. And while Plaintiff does not seek any form of monetary relief at this time, Plaintiff suspects that Defendant breached its fiduciary duties by overpaying claims to Defendant-related entities and to entities that pay Defendant kickbacks under the guise of "rebates" or other terms and labels.

JURY DEMAND

131. Plaintiff Owens & Minor, individually and on behalf of the Plan, hereby demands a trial by jury for all issues triable by jury.

PRAYER FOR RELIEF

132. Plaintiff seeks an order requiring Defendant to produce the Plan information and data previously requested by Plaintiff.

133. Plaintiff seeks declaratory relief as set forth above, *supra* paras. 109-112.

134. Plaintiff seeks specific performance of its contractual right to the claims information and data described above. Plaintiff has satisfied any and all conditions applicable to that right.

135. Plaintiff seeks reasonable attorney's fees and costs.

[Signature Block on Next Page]

Respectfully submitted,

THE LANIER LAW FIRM, P.C.

By: *W. Mark Lanier*

W. MARK LANIER
Texas State Bar No. 11934600
pro hac vice forthcoming
Kent C. Sullivan
Texas State Bar No. 19487300
pro hac vice forthcoming
Benjamin Major
Texas State Bar No. 24074639
pro hac vice forthcoming
10940 W. Sam Houston Pkwy N.
Suite 100
Houston, Texas 77064
Telephone: (713) 659-5200
Facsimile: (713) 659-2204
WML@lanierlawfirm.com
Kent.Sullivan@lanierlawfirm.com
Ben.Major@lanierlawfirm.com

PLEVIN AND GALLUCCI CO., LPA

FRANK GALLUCCI
Ohio State Bar No. 72680
pro hac vice forthcoming
55 Public Square
Suite 2222
Cleveland, Ohio 44113
Telephone: (216) 861-0804
Facsimile: (216) 861-5322
FGallucci@pglawyer.com

COMMONWEALTH LAW GROUP

Seth Carroll (VSB No. 74745)
Matthew Lastrapes (VSB No. 84097)
3311 West Broad Street
Richmond, VA 23230
Phone: (804) 551-9650

Facsimile: (866) 238-6415
scarroll@hurtinva.com
mlastrapes@hurtinva.com

ATTORNEYS FOR PLAINTIFFS

JS 44 (Rev. 04/21)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

OWENS & MINOR, INC. and OWENS & MINOR FLEXIBLE BENEFITS PLAN

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
SETH R. CARROLL, COMMONWEALTH LAW GROUP
3311 WEST BROAD ST., RICHMOND, VA 23230, 804-999-9999X2

DEFENDANTS

ANTHEM HEALTH PLANS OF VIRGINIA, INC. D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD

County of Residence of First Listed Defendant _____
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☑ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT	TORTS		FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance	**PERSONAL INJURY**	**PERSONAL INJURY**	☐ 625 Drug Related Seizure of Property 21 USC 881	☐ 422 Appeal 28 USC 158	☐ 375 False Claims Act
☐ 120 Marine	☐ 310 Airplane	☐ 365 Personal Injury - Product Liability	☐ 690 Other	☐ 423 Withdrawal 28 USC 157	☐ 376 Qui Tam (31 USC 3729(a))
☐ 130 Miller Act	☐ 315 Airplane Product Liability	☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability		**INTELLECTUAL PROPERTY RIGHTS**	☐ 400 State Reapportionment
☐ 140 Negotiable Instrument	☐ 320 Assault, Libel & Slander	☐ 368 Asbestos Personal Injury Product Liability		☐ 820 Copyrights	☐ 410 Antitrust
☐ 150 Recovery of Overpayment & Enforcement of Judgment	☐ 330 Federal Employers' Liability	**PERSONAL PROPERTY**	**LABOR**	☐ 830 Patent	☐ 430 Banks and Banking
☐ 151 Medicare Act	☐ 340 Marine	☐ 370 Other Fraud	☐ 710 Fair Labor Standards Act	☐ 835 Patent - Abbreviated New Drug Application	☐ 450 Commerce
☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)	☐ 345 Marine Product Liability	☐ 371 Truth in Lending	☐ 720 Labor/Management Relations	☐ 840 Trademark	☐ 460 Deportation
☐ 153 Recovery of Overpayment of Veteran's Benefits	☐ 350 Motor Vehicle	☐ 380 Other Personal Property Damage	☐ 740 Railway Labor Act	☐ 880 Defend Trade Secrets Act of 2016	☐ 470 Racketeer Influenced and Corrupt Organizations
☐ 160 Stockholders' Suits	☐ 355 Motor Vehicle Product Liability	☐ 385 Property Damage Product Liability	☐ 751 Family and Medical Leave Act	**SOCIAL SECURITY**	☐ 480 Consumer Credit (15 USC 1681 or 1692)
☐ 190 Other Contract	☐ 360 Other Personal Injury		☐ 790 Other Labor Litigation	☐ 861 HIA (1395ff)	☐ 485 Telephone Consumer Protection Act
☐ 195 Contract Product Liability	☐ 362 Personal Injury - Medical Malpractice		☑ 791 Employee Retirement Income Security Act	☐ 862 Black Lung (923)	☐ 490 Cable/Sat TV
☐ 196 Franchise				☐ 863 DIWC/DIWW (405(g))	☐ 850 Securities/Commodities/ Exchange
			IMMIGRATION	☐ 864 SSID Title XVI	☐ 890 Other Statutory Actions
			☐ 462 Naturalization Application	☐ 865 RSI (405(g))	☐ 891 Agricultural Acts
			☐ 465 Other Immigration Actions	**FEDERAL TAX SUITS**	☐ 893 Environmental Matters
				☐ 870 Taxes (U.S. Plaintiff or Defendant)	☐ 895 Freedom of Information Act
				☐ 871 IRS—Third Party 26 USC 7609	☐ 896 Arbitration
					☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
					☐ 950 Constitutionality of State Statutes

REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS
☐ 210 Land Condemnation	☐ 440 Other Civil Rights	**Habeas Corpus:**
☐ 220 Foreclosure	☐ 441 Voting	☐ 463 Alien Detainee
☐ 230 Rent Lease & Ejectment	☐ 442 Employment	☐ 510 Motions to Vacate Sentence
☐ 240 Torts to Land	☐ 443 Housing/ Accommodations	☐ 530 General
☐ 245 Tort Product Liability	☐ 445 Amer. w/Disabilities - Employment	☐ 535 Death Penalty
☐ 290 All Other Real Property	☐ 446 Amer. w/Disabilities - Other	**Other:**
	☐ 448 Education	☐ 540 Mandamus & Other
		☐ 550 Civil Rights
		☐ 555 Prison Condition
		☐ 560 Civil Detainee - Conditions of Confinement

V. ORIGIN *(Place an "X" in One Box Only)*

☑ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
ERISA, 29 USC 1001 et seq.

Brief description of cause:
ERISA Plan fiduciary declaratory action

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $ Declaratory relief, specific performance, costs and fees.

CHECK YES only if demanded in complaint:
JURY DEMAND: ☑ Yes ☐ No

VIII. RELATED CASE(S) IF ANY *(See instructions):*

JUDGE _____ DOCKET NUMBER _____

DATE

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

EXHIBIT A

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") is entered into by and between Owens & Minor Medical, Inc. ("Employer") and HealthKeepers, Inc. and Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield ("Anthem") and is effective as of June 1, 2017 upon the following terms and conditions:

1. Employer is the sponsor of a self-funded Group Health Plan (as defined below) providing, among other things, health care benefits to certain eligible employees and their qualified dependents.

2. Employer desires to retain Anthem as an independent contractor to administer certain elements of Employer's Group Health Plan.

3. Anthem desires to administer certain elements of Employer's Group Health Plan pursuant to the terms and conditions of this Agreement.

In consideration of the promises and the mutual covenants contained in this Agreement, Anthem and Employer (the "Party" or "Parties" as appropriate) agree as follows:

ARTICLE 1 - DEFINITIONS

For purposes of this Agreement and any amendments, attachments or schedules to this Agreement, the following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent:

ADMINISTRATIVE SERVICES FEES. The amount payable to Anthem in consideration of its administrative services and operating expenses as indicated in Section 3 of Schedule A, excluding any cost for stop loss insurance coverage or any other policy of insurance, if applicable. All additional charges not included in the Administrative Services Fees are specified elsewhere in this Agreement.

AGREEMENT PERIOD. The period of time indicated in Section 1 of Schedule A.

ANTHEM AFFILIATE. An entity controlling, under common control with or controlled by Anthem.

BENEFITS BOOKLET. A description of the portion of the health care benefits provided under the Plan that is administered by Anthem.

BILLED CHARGES. The amount that appears on a Member's Claim form (or other written notification acceptable to Anthem that Covered Services have been provided) as the Provider's charge for the services rendered to a Member, without any adjustment or reduction and irrespective of any applicable reimbursement arrangement with the Provider.

BLUE CROSS BLUE SHIELD ASSOCIATION ("BCBSA"). An association of independent Blue Cross and Blue Shield companies.

CLAIM. Written or electronic notice of a request for reimbursement of any health care service or supply on a form acceptable to Anthem.

CLAIMS RUNOUT SERVICES. Processing and payment of Claims that are incurred but unreported and/or unpaid as of the date this Agreement terminates.

COVERED SERVICE. Any health care service or supply rendered to Members for which benefits are eligible for reimbursement pursuant to the terms of the applicable Benefits Booklet.

EMPLOYER AFFILIATES. Companies affiliated with Employer that are participating in the Plan and which, along with the Employer constitute a single "control group" as that term is used in the Internal Revenue Code.

ERISA. The Employee Retirement Income Security Act of 1974, as amended, and regulations promulgated thereunder.

GROUP HEALTH PLAN OR PLAN. An employee welfare benefit plan (as defined in Section 3(1) of ERISA) established by the Employer, in effect as of the Effective Date, as described in the Plan Documents, as they may be amended from time to time.

INTER-PLAN ARRANGEMENTS. Blue Cross and Blue Shield Association programs, including the BlueCard Program, where Anthem can process certain Claims for Covered Services received by Members, which may include accessing the reimbursement arrangement of a Provider that has contracted with another Blue Cross and/or Blue Shield plan.

INVOICE DUE DATE. The date on the invoice provided to Employer indicating when payment is due.

MEMBER. The individuals, including the Subscriber and his/her dependents, as defined in the Benefits Booklet, who have satisfied the Plan eligibility requirements of Employer, applied for coverage, and been enrolled for Plan benefits.

NETWORK PROVIDER. A physician, health professional, hospital, pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with Anthem to provide Covered Services to Members through negotiated reimbursement arrangements.

PAID CLAIM. The amount charged to Employer for Covered Services or services provided during the term of this Agreement and any Claims Runout Period. Paid Claims may also include any applicable surcharges assessed by a state or government agency and any applicable interest paid. In addition, Paid Claims shall be determined as follows:

1. Provider and Vendor Claims. Except as otherwise provided in this Agreement, Paid Claims shall mean the amount Anthem actually pays the Provider or Vendor without regard to: (i) whether Anthem reimburses such Provider or Vendor on a percentage of charges basis, a fixed payment basis, a global fee basis, single case rate, or other reimbursement methodology; (ii) whether such amount is more or less than the Provider's or Vendor's actual Billed Charges for a particular service or supply; or (iii) whether such payments are increased or decreased by the Provider's or Vendor's achievement of, or failure to achieve, certain specified goals, outcomes or standards adopted by Anthem.

2. Prescription Drug Claims. If applicable to the Plan benefits as indicated in Schedule B, Paid Claims for Prescription Drugs shall mean an amount that Anthem invoices Employer for Prescription Drugs dispensed to Members by pharmacies. Anthem shall retain the difference, if any, between the amount invoiced to Employer and the amount paid to the pharmacy benefit manager ("PBM") for Prescription Drugs dispensed to Members as a portion of Anthem's reasonable compensation for services under this Agreement.

3. Payment Innovation Programs. If a Provider or Vendor participates in any Anthem payment innovation program, excluding any programs described in paragraph 1 of this provision, in which performance incentives, rewards or bonuses are paid based on the achievement of cost, quality, efficiency, or service standards or metrics adopted by Anthem ("Payment Innovation Programs"), Paid Claims shall also include the amount of such payments to Providers or Vendors for these Payment Innovation Programs. Such payments may be charged to Employer on a per Claim, lump sum, per Subscriber, or per Member basis and shall be based on Anthem's predetermined methodology for such Payment Innovation Program, as may be amended from time to time. The total monies charged in advance to fund a Payment Innovation Program shall be actuarially determined as the amount necessary to fund the expected payments attributable to the Payment Innovation Program. Prior to its implementation, Anthem shall provide Employer with a description of the Payment Innovation Program, the methodology that will be utilized to charge the Employer, and any reconciliation process performed in connection with such program. Payments to Providers or Vendors under these Payment Innovation Programs shall not impact Member cost shares.

4. Fees Paid to Manage and/or Coordinate Care or Costs. Paid Claims may also include fees paid to Providers or Vendors for managing and/or coordinating the care or cost of care for designated Members.

5. Claims Payment Pursuant to any Judgment, Settlement, Legal or Administrative Proceeding. Paid Claims shall include any Claim amount paid as the result of a settlement, judgment, or legal, regulatory or administrative proceeding brought against the Plan and/or Anthem, or otherwise agreed to by Anthem, with respect to the decisions made by Anthem regarding the coverage of or amounts paid for services under the terms of the Plan. Paid Claims also includes any amount paid as a result of Anthem's billing dispute resolution procedures with a Provider or Vendor. Any Claims paid pursuant to this provision will count towards any stop loss accumulators under a stop loss agreement with Anthem.

6. Claims Payment Pursuant to Inter-Plan Arrangements and Other BCBSA Programs. Paid Claims shall include any amount paid for Covered Services that are processed through Inter-Plan Arrangements or for any amounts paid for Covered Services provided through another BCBSA program (e.g., BCBSA Blue Distinction Centers for Transplant). More information about Inter-Plan Arrangements is found in the Inter-Plan Arrangements Schedule of this Agreement.

7. Claims Payment Pursuant to a Consumer Directed Health Plan Account. If applicable to Plan benefits and as indicated on Schedule B of this Agreement, Paid Claims shall include any amount actually paid by Anthem from a consumer directed health plan account, such as a health reimbursement account or a health incentive account.

PLAN DOCUMENTS. The documents that set forth the terms of the Plan, and which include the Summary Plan Description and the Benefits Booklet.

PRESCRIPTION DRUG. Insulin and those drugs and drug compounds that are included in the U.S. Pharmacopoeia and that are required to be dispensed pursuant to a prescription or that are otherwise included on Anthem's formulary (e.g., certain over-the-counter drugs).

PROPRIETARY INFORMATION AND CONFIDENTIAL INFORMATION. Employer's Proprietary Information is information about the systems, procedures, methodologies and practices used by Employer to run its operations and the Plan and other non-public information about Employer. Anthem's Proprietary Information is non-public, trade secret, commercially valuable, or competitively sensitive information, or other material and information relating to the products, business, or activities of Anthem or an Anthem Affiliate, including but not limited to: (1) Information about Anthem's Provider networks, Provider negotiated fees, Provider discounts, and Provider contract terms; (2) information about the systems, procedures, methodologies, and practices used by Anthem and Anthem Affiliates in performing their services such as underwriting, Claims processing, Claims payment, and health care management activities; and (3) combinations of data elements that could enable information of this kind to be derived or calculated. Anthem's Confidential Information is information that Anthem or an Anthem Affiliate is obligated by law or contract to protect, including: (1) Social Security numbers; (2) Provider tax identification numbers (TINs); (3) National Provider Identification Numbers (NPIs); (4) Provider names, Provider addresses, and other identifying information about Providers; and (5) drug enforcement administration (DEA) numbers, pharmacy numbers, and other identifying information about pharmacies.

PROVIDER. A duly licensed physician, health professional, hospital, pharmacy or other individual, organization and/or facility that provides health services or supplies within the scope of an applicable license and/or certification and meets any other requirements set forth in the Benefits Booklet.

SUBSCRIBER. An employee or retiree of Employer or other eligible person (other than a dependent) who is enrolled in the Plan.

SUMMARY PLAN DESCRIPTION ("SPD"). A document provided to Subscribers by Employer or its designee that describes the health care benefits available to Members under the Plan, their rights under the Plan and the obligations of the Plan. This document may incorporate the Benefits Booklet. In the event of any conflict or inconsistency between the Summary Plan Description and the Benefits Booklet, the terms of the Benefits Booklet shall control Anthem's performance under this Agreement.

VENDOR. A person or entity other than a Provider, including an Anthem Affiliate, that provides services or supplies pursuant to a contract with Anthem.

ARTICLE 2 - ADMINISTRATIVE SERVICES PROVIDED BY ANTHEM

a. Anthem shall process the enrollment of eligible individuals and termination of Members as directed by the Employer subject to the provisions of this Agreement. Anthem shall, with the assistance of Employer, respond to direct routine inquiries made to it by employees and other persons concerning eligibility in the Plan.

b. Anthem shall perform the following Claims administrative services:

1. Process Claims with a Claims Incurred Date indicated in Section 1 of Schedule A and provide customer service, including investigating and reviewing such Claims to determine what amount, if any, is due and payable according to the terms and conditions of the Benefits Booklet and this Agreement. Anthem shall perform coordination of benefits ("COB") with other payors, including Medicare. In processing Claims, Anthem shall utilize Anthem's medical policies and medical policy exception process, its definition of medical necessity, its precertification and/or preauthorization policies, Provider contract requirements and applicable Claim timely filing limits.
2. Disburse to the applicable individuals or entities (including Providers and Vendors) payments that it determines to be due according to the provisions of the Benefits Booklet.

3. Provide notice in writing when a Claim for benefits has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Benefits Booklet and shall otherwise satisfy applicable regulatory requirements, including those of ERISA, governing the notice of a denied Claim.

c. Pursuant to Section 405(c)(1) of ERISA, Employer delegates to Anthem fiduciary authority to determine claims for benefits under the Plan as well as the authority to act as the appropriate fiduciary under Section 503 of ERISA to determine appeals of any adverse benefit determinations under the Plan. Anthem shall administer complaints, appeals and requests for independent review according to Anthem's complaint and appeals policy, and any applicable law or regulation, unless otherwise provided in the Benefits Booklet. In carrying out this authority, Anthem is delegated full discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan. Anthem shall be deemed to have properly exercised such authority unless a Member proves that Anthem has abused its discretion or that its decision is arbitrary and capricious. Anthem is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement and only to the extent that its performance of such actions constitutes fiduciary action under ERISA. Anthem shall have no fiduciary responsibility in connection with any other element of the administration of the Plan. Anthem shall not act as the "plan administrator" nor shall it be a "named fiduciary" of the Plan. Anthem shall charge Employer the fee described in Section 3.C of Schedule A for any independent review conducted pursuant to this provision.

d. Anthem shall have the authority, in its reasonable discretion, to institute from time to time, utilization management, case management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of Anthem's ongoing effort to find innovative ways to make available high quality and more affordable healthcare services. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the applicable Benefits Booklet, unless otherwise agreed to by the Employer. Anthem reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.

e. Anthem shall perform recovery services as provided in Article 13.

f. Anthem shall issue identification cards to Subscribers and/or Members, as applicable, and the content and design of the identification cards shall comply with BCBSA regulations.

g. This provision is intentionally omitted in its entirety.

h. Anthem shall provide Members and potential Members access to an online directory of Providers contracted with Anthem ("Provider Directories"). Such Provider Directories shall also be available and distributed in booklet format upon Member request. Additionally, if applicable to Plan benefits, Anthem shall ensure that Members and potential Members have access to the BlueCard directory of Providers via a website sponsored by BCBSA.

i. Anthem reserves the right to make benefit payments to either Providers or Members at its reasonable discretion. Employer agrees that the terms of the Plan will include provisions for supporting such discretion in determining the direction of payment including, but not limited to, a provision prohibiting Members from assigning their rights to receive benefit payments, unless otherwise prohibited by applicable law.

j. If applicable to the Plan benefits and as indicated in Schedule B of this Agreement, Anthem may provide or arrange for the provision of the following managed care services:

1. Conduct medical necessity review, utilization review, and a referral process, which may include, but is not limited to: (a) preadmission review to evaluate and determine the medical necessity of an admission or procedure and the appropriate level of care, and for an inpatient admission, to authorize an initial length of stay; (b) concurrent review throughout the course of the inpatient admission for authorization of additional days of care as warranted by the patient's medical condition; (c) retrospective review; and (d) authorizing a referral to a non-Network Provider. Anthem shall have the authority to waive a requirement if, in Anthem's discretion, such exception is in the best interest of the Member or the Plan, or is in furtherance of the provision of cost effective services under this Agreement.

2. Perform case management to identify short and long term treatment programs in cases of severe or chronic illness or injury. Anthem may, but is not required to, customize benefits in limited circumstances by approving otherwise non-Covered Services if, in the discretion of Anthem, such exception is in the best interest of the Member and the Plan.

3. Provide access to a specialty network of Providers if the Plan includes a specialty network. Anthem reserves the right to establish specialty networks for certain specialty or referral care.

4. Provide any other managed care services incident to or necessary for the performance of the services set forth in this Article 2.

k. If applicable to the Plan benefits and as indicated in Schedule A or B of this Agreement, Anthem shall offer wellness programs and other programs to help Employer effectively manage the cost of care, and Employer shall pay fees for the programs selected by Employer only if such fees are indicated in Section 3(B) of Schedule A. Employer shall abide by all applicable policies and procedures of the programs selected, which may require Employer to provide requested information prior to Anthem initiating the service.

l. On behalf of Employer, Anthem shall produce and maintain a master copy of the Benefits Booklet and make changes and amendments to the master copy of the Benefits Booklet and incorporate any approved changes or amendments pursuant to Article 18(a) of this Agreement. Employer shall determine, in its sole and reasonable discretion, whether Anthem has accurately produced the Benefits Booklet and has fully implemented the approved changes or amendments. Until Employer has approved the Benefits Booklet, Anthem will administer the quoted benefits according to Anthem's most similar standard Benefits Booklet language.

m. Anthem will provide Employer with Plan data and assistance necessary for preparation of the Plan's information returns and forms required by ERISA or other federal or state laws. Anthem shall prepare and mail all IRS Form 1099's and any other similar form that is given to Providers or brokers. Form 5500s are the sole responsibility of Employer; however, Anthem shall provide timely information and, if requested, assistance. Anthem will disclose its fee and compensation information to Employer, as required by applicable law, for Employer to complete its Form 5500 and assess its compliance with section 408(b)(2) of ERISA and any applicable regulations promulgated there under. Employer is solely responsible for preparing the summary annual reports.

n. Anthem shall administer unclaimed funds pursuant to unclaimed property or escheat laws and shall make any required payment and file any required reports under such laws.

o. Unless otherwise agreed to by the Parties and specified in the Benefits Booklet, Anthem's standard policies and procedures, as well as Provider contracts, as they may be amended from time to time, will be used in the provision of services specified in this Agreement. In the event of any conflict between this Agreement and any of Anthem's policies and procedures, this Agreement will govern.

p. This provision is intentionally omitted.

q. Select state laws require Employers to finance health related initiatives through residency-based assessments and/or surcharges added to certain Paid Claims. After Employer completes any applicable forms, Anthem shall make all assessment and/or surcharge payments on behalf of Employer to the appropriate pools administered by the respective states, based primarily upon Anthem's Paid Claims information and Member information provided to Anthem by Employer. Examples of such assessments and surcharges include, but are not limited to, the Massachusetts Health Safety Net Trust Fund, the New York Health Care Reform Act and the Michigan Health Insurance Claims Assessment Act.

r. Anthem shall provide required notices describing Member's rights under the Women's Health and Cancer Rights Act (WHCRA) upon a Member's enrollment and at least annually thereafter.

s. Anthem shall have the authority, in its sole discretion, to build and maintain its Provider network on its own behalf. In building and maintaining its Provider network, Anthem is not acting on behalf of or as an agent for any Employer or member. Nothing in this Agreement shall be interpreted to require Anthem to maintain negotiated fees or reimbursement arrangements or other relationships with certain Providers or Vendors or to negotiate on behalf of or for the benefit of Employer or Employer's Members. Anthem will be solely responsible for acting as a liaison with Providers including, but not limited to, responding to Provider inquiries, negotiating contract language and negotiating rates with Providers or auditing Providers, and Employer agrees that it will be subject to the terms and conditions of these agreements.

t. If a catastrophic event (whether weather-related, caused by a natural disaster, or caused by war, terrorism, or similar event) occurs that affects Members in one or more locations, and such catastrophic event prevents or interferes with Anthem's ability to conduct its normal business with respect to such Members or prevents or interferes with Members' ability to access their benefits, Anthem shall have the right, without

first seeking consent from Employer, to take reasonable and necessary steps to process Claims and provide managed care services in a manner that may be inconsistent with the Benefits Booklet in order to minimize the effect such catastrophic event has on Members. As soon as practicable after a catastrophic event, Anthem shall report its actions to Employer. Employer shall reimburse Anthem for amounts paid in good faith under the circumstances and such amounts shall constitute Paid Claims, even if the charges incurred were not for services otherwise covered under the Benefits Booklet.

u. Anthem shall submit any claim that is required to be filed under any stop loss policy issued by Anthem or an Anthem Affiliate. Anthem shall have no obligation to prepare or file any claim for excess risk or stop loss coverage under a policy not issued by Anthem or an Anthem Affiliate. Anthem shall provide Employer with Claims data pursuant to Article 11 of this Agreement if Employer chooses to file a claim under a stop loss policy issued by an entity other than Anthem or an Anthem Affiliate. Anthem shall assume no liability or responsibility to Employer for inconsistencies between the determination of Covered Services under the Benefits Booklet and this Agreement and the determination of coverage by an unaffiliated stop loss carrier.

v. Anthem shall assist Employer in determining whether its Prescription Drug benefit constitutes "creditable prescription drug coverage" as that term is used under the Medicare Part D laws (specifically, 42 C.F.R. 423.56). Unless otherwise agreed to by the Parties, Employer shall be solely responsible for communicating with Members regarding creditable prescription drug coverage matters.

w. If a Member is a Massachusetts resident, Anthem shall mail the Member any notices required by the Massachusetts Health Care Reform Act ("HCRA") reflecting coverage during the current and prior Agreement Period. If a Member works in Massachusetts for Employer, but resides in another State, Anthem will only provide such notices if Employer notifies Anthem at least 60 days prior to any notice deadline imposed by HCRA that such Member requires the HCRA notices.

x. Anthem is the responsible reporting entity ("RRE") for the Plan as that term is defined pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. In order to fulfill its RRE obligation, Anthem requires information from the Employer, including, but not limited to, Member Social Security Numbers. Employer shall cooperate with Anthem and timely respond to any request for information made by Anthem.

y. Anthem will provide Employer with Plan information and assistance necessary for the preparation of the Plan's Summary of Benefits and Coverage ("SBC") related to the elements of the Plan that Anthem administers. Employer is solely responsible for ensuring that the SBC accurately reflects the benefits Employer will offer and for finalizing and distributing the SBC to Subscribers. Notwithstanding the provisions in Article 18(a), if Employer's open enrollment period is at a time other than 30 days prior to the end of an Agreement Period, Employer agrees to provide Anthem with any changes to the benefits Anthem administers at least 60 days prior to the start of the open enrollment period.

ARTICLE 3 - OBLIGATIONS OF EMPLOYER

a. Employer shall furnish to Anthem initial eligibility information regarding Members. Employer is responsible for determining eligibility of individuals and advising Anthem in a timely manner, through a method agreed upon by the Parties, as to which employees, dependents, and other individuals are to be enrolled Members. Anthem reserves the right to limit the effective date of retroactive enrollment to a date not earlier than 60 days prior to the date notice is received. Such retroactive enrollments shall be subject to Anthem's receipt of any applicable fees as indicated in Section 3 of Schedule A. Employer shall keep such applicable records and furnish to Anthem such notification and other information as may be required by Anthem for the purpose of enrolling Members, processing terminations, effecting COBRA coverage elections, effecting changes in single or family coverage status, effecting changes due to a Member becoming eligible or ineligible for Medicare, effecting changes due to a leave of absence, or for any other purpose reasonably related to the administration of eligibility under this Agreement. Employer acknowledges that prompt and complete furnishing of the required eligibility information is essential to the timely, accurate, and efficient processing of Claims.

Employer shall notify Anthem monthly of the Subscribers, dependents, or other individuals that will be or have become ineligible for benefits under the Plan. Upon receipt of such notice, Anthem shall terminate coverage effective as of the date specified in the Benefits Booklet. Employer shall give Anthem advance notice, if possible, of any Member's expected termination and/or retirement. Anthem reserves the right to limit retroactive terminations to a maximum of 60 days prior to the date notice is received. Anthem shall credit Employer any applicable fees for such retroactive terminations as indicated in Section 3 of Schedule

A.
If Anthem has paid Claims for persons no longer eligible for reasons including, but not limited to, Anthem having been provided inaccurate eligibility information, or Anthem having received notice of a retroactive change to enrollment, then Employer shall reimburse Anthem for all unrecovered Paid Claim amounts to the extent that the amounts have not already been paid by Employer.

b. Employer acknowledges that it or its designee(s) serves as the "plan sponsor, "plan administrator" and "named fiduciary" as those terms are defined in ERISA. Employer has all discretionary authority and control over the management of the Plan, and all discretionary authority and responsibility for the administration of the Plan except as delegated to Anthem in Article 2(c) of this Agreement. Anthem does not serve as "plan sponsor", "plan administrator" or as the Plan's "named fiduciary". Employer retains all final authority and responsibility for the Plan and its operation and Anthem is empowered to act on behalf of Employer in connection with the Plan only as expressly stated in this Agreement or as otherwise agreed to by the Parties in writing.

c. It is understood and agreed that the provision of any notice, election form, or communication and the collection of any applicable premium or fees required by or associated with Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or any other applicable law governing continuation of health care coverage, shall be the responsibility of Employer and not Anthem, except as otherwise agreed to in a written agreement between the Parties.

d. Employer is responsible for compliance with the Family and Medical Leave Act ("FMLA") and, to the extent applicable to Employers' wellness program(s), for compliance with the Americans with Disabilities Act, the Internal Revenue Code, federal and state nondiscrimination laws, and other applicable federal and state laws and regulations governing wellness programs.

e. Employer agrees to and shall collect those contributions from Subscribers that are required by Employer for participation in the Plan. If Employer elects Anthem's stop loss coverage, Employer shall abide by Anthem's participation and contribution guidelines.

f. Unless otherwise agreed to by the Parties in writing, Employer shall prepare and distribute SPDs, summary annual reports, and all notices or summaries of changes or material modifications to the Plan. Employer shall confirm that when it or its designee prepares the SPD, such SPD will accurately reflect the terms of the Benefits Booklet.

g. To the extent that Medicare, Medicaid, the Veterans Administration or any other federal or state agency or entity asserts a reimbursement right against Employer, the Plan, or Anthem pursuant to that agency's or entity's rights under applicable law with respect to Claims processed by Anthem under this Agreement, the Employer shall be responsible for reimbursing Anthem any such amounts determined to be owed.

h. Employer shall give notice to Anthem of the expected occurrence of any of the following events (including a description of the event), with such notice to be given at least 30 days prior to the effective date of the event, unless such advance notice is prohibited by law or contract in which case, notice will be provided as soon as practicable:

1. Change of Employer's name;

2. Any merger between or consolidation with another entity where, after such merger or consolidation, Employer is not the controlling entity;

3. The sale or other transfer of all or substantially all of the assets of either Employer or any Employer Affiliates or the sale or other transfer of the equity of Employer or any Employer Affiliates, or;

4. Any bankruptcy, receivership, insolvency or inability of Employer to pay its debts as they become due.

i. The Employer shall have the responsibility, in accordance with state or federal law, to develop procedures for determining whether a medical child support order is a "qualified" medical child support order. The Employer shall provide notice to Anthem once it has made such determination.

j. The Employer may request Anthem, on an exception basis, to process and pay Claims that were denied by Anthem or take other actions with respect to the Plan that are not specifically set forth in this Agreement or the Benefits Booklet. In such cases, any payments shall not count toward the stop loss accumulators under a stop loss agreement issued by Anthem, unless otherwise agreed to by Anthem. Anthem may charge Employer a processing fee that has been mutually agreed to by the Parties prior to the processing of the Claim. Anthem shall not be responsible for any liability associated with any act or omission undertaken at the direction of, or in accordance with, instructions received from the Employer under this provision.

ARTICLE 4 - CLAIMS PAYMENT METHOD

a. Employer shall pay or fund Paid Claims according to the Claims payment method described in Section 4 of Schedule A. Employer shall pay or fund such amounts by the Invoice Due Date. In addition, from time to time, the Parties acknowledge that Employer may request a review of the appropriateness of a Claim payment and, during the review period, Employer shall pay or fund such Claim.

b. The Parties acknowledge that, from time to time, a Claims adjustment may be necessary as a result of coordination of benefits, subrogation, workers' compensation, other third party recoveries, payment errors and the like, and that the adjustment will take the form of a debit (for an additional amount paid by Anthem) or a credit (for an amount refunded to Employer). The Parties agree that such Claims adjustment shall be treated as an adjustment to the Claims payment made in the billing period in which the adjustment occurs, rather than as a retroactive adjustment to the Claim in the billing period in which it was initially reported as paid. Any Claims credit may be reduced by a fee as indicated in Schedule A of this Agreement. In addition, a credit shall not be provided to Employer for a recovery related to a Claim that was covered under stop loss coverage provided by Anthem.

ARTICLE 5 - ADMINISTRATIVE SERVICES FEES

During the term of this Agreement, Employer shall pay Anthem the Administrative Services Fees, described in Section 3 of Schedule A. Employer shall pay the Administrative Services Fees and other fees authorized under this Agreement by the applicable Invoice Due Date according to the payment method described in Section 5 of Schedule A.

ARTICLE 6 - RENEWAL SCHEDULES

If Anthem offers to renew this Agreement at the end of an Agreement Period, then Anthem shall provide Employer with the terms and conditions of the proposed renewal in writing within the time period provided in Section 1 of Schedule A. Employer shall notify Anthem in writing of its selection from the renewal options by indicating its selection and signing Anthem's designated renewal form. If Anthem does not receive a signed acceptance of the renewal from Employer prior to the start of the next Agreement Period, Employer's payment of the amounts set forth in the renewal shall constitute Employer's acceptance of the terms. Anthem shall provide a revised Schedule A that will become part of this Agreement without the necessity of securing Employer's signature.

ARTICLE 7 - CLAIMS RUNOUT SERVICES

a. Claims Runout Services shall be provided for the period of time provided in Section 6 of Schedule A (the "Claims Runout Period"), except such Claims Runout services shall not be provided in the event that termination is due to non-payment pursuant to Article 19(a) of this Agreement. During the Claims Runout Period, the terms of this Agreement shall continue to apply. Anthem shall have no obligation to process or pay any Claims or forward Claims to Employer beyond the Claims Runout Period. Any amounts recovered beyond the Claims Runout Period shall be retained by Anthem as reasonable compensation for services under this Agreement. Anthem shall, however, as soon as practicable return any recoveries for which Anthem had received monies, but had not processed the recovery prior to the end of the Claims Runout Period. In addition, Employer shall have no obligation to reimburse Anthem for any amounts paid by Anthem due to adjustments to Claims after the end of the Claims Runout Period.

b. The Administrative Services Fee for the Claims Runout Period, if applicable, is provided in Section 6 of Schedule A. Paid Claims and the Administrative Services Fee shall be invoiced and paid in the same manner as provided in Sections 4 and 5 of Schedule A, unless otherwise provided or agreed to in writing by

the Parties.

ARTICLE 8 - LATE PAYMENT PENALTY

If Employer fails to timely pay or fund any amount due to Anthem under this Agreement, Employer agrees to pay a late payment penalty for each day the payment is late. The late payment penalty shall be calculated at the rate of 12% simple interest per annum (365 days), and shall be included on a subsequent invoice and payable by the Invoice Due Date. If applicable, Employer agrees to reimburse Anthem for any expenses charged to Anthem by a financial institution, Provider or Vendor due to Employer's failure to maintain sufficient funds in a designated bank account. Any acceptance by Anthem of late payments shall not be deemed a waiver of its rights to terminate this Agreement for any future failure of Employer to make timely payments. Anthem will notify Employer in writing of the delinquency before applying any late payment penalty as described in this provision.

ARTICLE 9 - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

a. Anthem's duties and responsibilities in connection with the requirements imposed by the Health Insurance Portability and Accountability Act ("HIPAA") and the privacy and security regulations promulgated thereunder will be set forth in a separate business associate agreement between the Parties.

b. In the event the Plan submits Claims or eligibility inquiries or any other HIPAA covered transaction as defined in 45 CFR Part 160 and 162 to Anthem through electronic means, the Plan and Anthem shall comply with all applicable requirements of HIPAA and the Plan and Anthem shall require any of their respective agents or subcontractors to comply with all applicable requirements of HIPAA.

ARTICLE 10 - PROPRIETARY AND CONFIDENTIAL INFORMATION

a. Each Party retains ownership of its Proprietary Information and Confidential Information (collectively "Information") and neither conveys ownership rights in its Information nor acquires ownership rights in the other Party's Information by entering into this Agreement or performing its obligations hereunder. Nothing in this Agreement shall impair or limit a Party's right to use and disclose its Information for its own lawful business purposes.

b. Each Party shall maintain the other Party's Information in strict confidence, and shall institute commercially reasonable safeguards to protect it.

c. Employer shall use and disclose Anthem's Information solely for the purpose of administering the Plan. Employer shall not, without Anthem's advance written consent, (1) use or disclose Anthem's Information, or reports or summaries thereof, for any purpose other than administering the Plan; (2) combine Anthem's Information with other data to create or add to an aggregated database that will or could be made available to any third party; (3) combine Anthem's Information provided for a particular purpose with Anthem's Information provided for another purpose; or (4) sell or disclose Anthem's Information to any other person or entity except as expressly permitted by this Article 10.

d. Employer may disclose the minimum amount of Anthem's Information necessary to Employer's stop loss carriers, consultants, auditors, and other third parties engaged by Employer (each a "Plan Contractor"), provided that: (i) each such third party needs to know such Information in order to provide services to Employer; (ii) the restrictions set forth in subsection c. of this Article 10 shall apply to each such third party as well as to Employer; and (iii) prior to such disclosure, each such third party shall enter into a confidentiality agreement (or an appropriate amendment to an existing one, as applicable) with Anthem, with respect to the planned disclosure.

e. Upon termination of this Agreement, each Party shall return or destroy the other Party's Information or retain the Information in accordance with its record retention policies and procedures; provided; however that each Party shall continue to comply with the provisions of this Article 10 for as long as it retains the other Party's Information.

f. This Agreement shall not be construed to restrict the use or disclosure of information that: (1) is public knowledge other than as a result of a breach of this Agreement; (2) is independently developed by a Party not in violation of this Agreement; (3) is made available to a Party by any person other than the other Party, provided the source of such information is not subject to any confidentiality obligations with respect to it; or,

(4) is required to be disclosed pursuant to law, order, regulation or judicial or administrative process, but only to the extent of such required disclosures and after reasonable notice to the other Party.

ARTICLE 11 - DATA REPORTS

a. Upon Employer's request and only as permitted by the business associate agreement entered into between the Parties, Anthem will provide Anthem's standard account reporting package. Prior to Anthem providing data or reports to Employer, the Parties must mutually agree to the types, format, content and purpose of the reports requested. If Employer requests from Anthem information that is not part of Anthem's standard account reporting package, and such request is approved by Anthem, Employer agrees to pay a mutually agreed upon charge to Anthem for such additional reports.

b. If Employer requests Anthem to provide a data extract or report to any Plan Contractor for use on Employer's behalf and Anthem agrees to do so: (i) to the extent such extract or report includes protected health information ("PHI") as defined in HIPAA, Anthem's disclosure of the PHI and Plan Contractor's subsequent obligations with respect to the protection, use, and disclosure of the PHI will be governed by Employer's applicable business associate agreements with Anthem and the Plan Contractor; and (ii) to the extent such data or report includes Anthem's Proprietary Information and/or Anthem's Confidential Information, Employer acknowledges and agrees that Plan Contractor shall be subject to the restrictions set forth in Article 10 of this Agreement and shall enter into a confidentiality agreement with Anthem (or amend an existing one, as applicable) prior to Anthem's release of the extract or report.

c. Employer agrees not to contact, or to engage or permit a Plan Contractor to contact on Employer's behalf, any health care Provider concerning the information in any reports or data extracts provided by Anthem unless the contact is coordinated by Anthem.

d. In addition to their unlimited rights to use Anthem's Proprietary Information and Confidential Information, Anthem and Anthem Affiliates shall also have the right to use and disclose other Claim-related data collected in the performance of services under this Agreement or any other agreement between the Parties, so long as: (1) the data is de-identified in a manner consistent with the requirements of HIPAA; or (2) the data is used or disclosed for research, health oversight activities, or other purposes permitted by law; or (3) a Member has consented to the release of his or her individually identifiable data. The data used or disclosed shall be used for a variety of lawful purposes including, but not limited to, research, monitoring, benchmarking and analysis of industry and health care trends. Anthem may receive remuneration for the data only if permitted by HIPAA.

ARTICLE 12 - CLAIMS AUDIT

a. At Employer's expense, Employer shall have the right to audit Claims on Anthem's premises, during regular business hours and in accordance with Anthem's audit policy, which may be revised from time to time. A copy of the audit policy shall be made available to Employer upon request.

b. If Employer elects to utilize a third-party auditor to conduct an audit pursuant to this Agreement and Anthem's audit policy, such auditor must be mutually acceptable to Employer and Anthem. Anthem will only approve auditors that are independent and objective and will not approve auditors paid on a contingency fee or other similar basis. Anthem reserves the right to charge a fee to Employer for expenditure of time by Anthem's employees in completing any audit which fee shall be reasonable, based on Anthem's actual cost of the services of employees completing the audit. An auditor or consultant must execute and indemnification agreement with Anthem pertaining to Anthem's Proprietary and Confidential Information prior to conducting an audit.

c. Employer may conduct an audit once each calendar year and the audit may only relate to Claims processed during the current year or immediately preceding calendar year (the "Audit Period") and neither Employer nor anyone acting on Employer's or the Plan's behalf, shall have a right to audit Claims processed prior to the Audit Period. The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit.

d. Employer shall provide to Anthem copies of all drafts, interim and/or final audit reports at such time as they are made available by the auditor or consultants to Employer. Any errors identified as the result of the audit shall be subject to Anthem's review and acceptance prior to initiating any recoveries of Paid Claims pursuant to Article 13 of this Agreement. Anthem reserves the right to terminate any audit being performed

by or for Employer if Anthem determines that the confidentiality of its information is not properly being maintained or if Anthem determines that Employer or auditor is not following Anthem audit policy.

e. An audit performed pursuant to this Agreement shall be the final audit for the Audit Period and for any prior Audit Period unless otherwise agreed to in writing by the Parties; however, Claims may be re-audited if Employer is required to conduct the audit by a government agency with which it has a contractual arrangement.

ARTICLE 13 - RECOVERY SERVICES

a. Pursuant to the provisions of this Article 13(a), Anthem shall review Paid Claims processed under this Agreement (including during any Claims Runout Period) to determine whether such Claims have been paid accurately and identify recoveries that can be pursued. Employer will receive the entire amount of any recovery obtained on its behalf. In performing these recovery services, Anthem shall not be obligated to retain outside counsel or other third parties if Anthem's recovery efforts are not successful. The cost of these services provided by Anthem for recovery efforts under this Article 13(a) is included in Anthem's Administrative Services Fee, as set forth in Section 3(A) ("Base Administrative Services Fee") of Schedule A.

b. Anthem may become aware of additional recovery opportunities by means other than reviewing Paid Claims processed under this Agreement. Employer grants Anthem the authority and discretion in those instances to do the following: (1) determine and take steps reasonably necessary and cost-effective to effect recovery; (2) select and retain outside counsel; (3) reduce any recovery obtained on behalf of the Plan by its proportionate share of the outside counsel fees and costs incurred during litigation or settlement activities to obtain such recovery; and (4) negotiate and effect any settlement of Employer's and Plan's rights by, among other things, executing a release waiving Employer's and Plan's rights to take any action inconsistent with the settlement.

c. During the term of this Agreement and any applicable Claims Runout Period, Anthem may pursue payments to Members by any other person, insurance company or other entity on account of any action, claim, request, demand, settlement, judgment, liability or expense that is related to a Claim for Covered Services ("Subrogation Services"). Anthem shall charge Employer a fee provided in Schedule A to this Agreement ("Subrogation Fee"). Any subrogation recoveries shall be net of the Subrogation Fee. Subrogation Fees will not be assessed on subrogation recoveries until they are received by Anthem and credited to Employer.

d. Anthem will engage third parties: (1) to conduct a review of Paid Claims processed under this Agreement and perform other recovery related services that are in addition to the standard recovery services provided under Article 13(a); and, (2) to conduct audits of Provider and Vendor contracts. The purpose of these services is to determine whether Paid Claims processed under this Agreement have been paid accurately and, if they have not been paid accurately, to pursue recoveries. If Anthem makes a recovery as a result of the services described in this Article 13(d), then Anthem shall receive a fee provided in Schedule A as compensation for its services, a portion of which shall be paid to third parties for their services, and Employer will receive the remaining recovery amount.

e. In exercising its authority pursuant to Articles 13(a) through (d), Anthem shall determine which recoveries it will pursue, and in no event will Anthem pursue a recovery if it reasonably believes that the cost of the collection is likely to exceed the recovery amount or if the recovery is prohibited by law or an agreement with a Provider or Vendor. Anthem will not be liable for any amounts it does not successfully recover. Anthem shall retain any recoveries it obtains as a result of its recovery services or audits if the cost to administer the refund is likely to exceed the amount of the refund. Employer further understands and agrees that Anthem shall have authority to enter into a settlement or compromise on behalf of Employer and Plan regarding these recovery, subrogation and audit services, including, but not limited to, the right to reduce future reimbursement to Provider or Vendor in lieu of a lump sum settlement. Anthem may have contracts with Network Providers or Vendors or there may be judgments, orders, settlements, applicable laws or regulations that limit Anthem's right to make recoveries under certain circumstances. Anthem may, but is not required to, readjudicate Claims or adjust Members' cost share payments related to the recoveries made from a Provider or a Vendor. Anthem shall credit Employer net recovery amounts after deduction of fees and costs as set forth in this Article 13 not later than 150 days following the receipt of the total recovery amount. If Anthem does not credit Employer within 150 days of its receipt of the total recovery amount, Anthem shall pay Employer interest calculated at the Federal Reserve Funds Rate in

effect at the time of the payment. In no event, however, will Anthem be liable to credit Employer for any recovery after the termination date of this Agreement and any Claims Runout Period, and Employer acknowledges and agrees that such sums shall be retained by Anthem as reasonable compensation for recovery services provided by Anthem.

ARTICLE 14 - PHARMACY BENEFITS AND SERVICES

a. If applicable to Plan benefits and as indicated in Schedule B of this Agreement, Anthem, through PBM, shall provide the following Prescription Drug management services:

1. Anthem shall offer Employer access to a network of pharmacies that have entered into contractual arrangements with PBM under which such pharmacies agree to provide pharmacy services to Members and accept negotiated fees for such services ("Network Pharmacies"). Anthem shall determine, in its sole discretion, which pharmacies shall be Network Pharmacies, and the composition of Network Pharmacies may change from time to time.

2. Anthem will furnish and maintain a drug formulary for use with the Plan, and Anthem shall periodically review and update its formulary. The Employer shall adopt such formulary as part of the design of the Plan. Unless mutually agreed to in writing by the Parties, upon termination of the Agreement, the Employer shall cease adoption and use of Anthem's formulary as part of its Plan. The drug formulary will be made available to Members on Anthem's web site and upon request may be provided to Employer in a mutually acceptable format for Employer's distribution to Members.

3. Anthem shall offer Employer a home delivery pharmacy program, through which Members may receive home delivery prescription services. Additional fees for express mail, shipping or handling may be charged to Members. Anthem shall also offer Employer a specialty pharmacy program, through which Members may receive specialty pharmacy prescription services. Anthem shall provide all necessary information and forms to Members to obtain these services.

4. Anthem shall arrange for the processing of Prescription Drug Claims in accordance with the Benefits Booklet.

b. PBM has negotiated programs with pharmaceutical manufacturers under which rebates for certain Prescription Drugs dispensed to Members are made directly to PBM ("Drug Rebate Programs"). Such Drug Rebate Programs are not based on the drug utilization of any one Employer Plan, but rather are based on the drug utilization of all individuals enrolled in PBM managed programs. In many cases the rebates are conditioned on certain Prescription Drugs being included on the formulary that Anthem requires Employer to adopt as part of the Plan. PBM will pay Anthem a portion of the rebates it receives (such portion being referred to in this Agreement as "Drug Rebates"). Anthem shall pay Employer an amount attributable to its actual or estimated receipt of the Drug Rebates as described in Section 3(A) of Schedule A.

c. Anthem may receive and retain administrative fees from PBM or directly from pharmaceutical manufacturers. In addition, Anthem may receive and retain service fees from pharmaceutical manufacturers for providing services (e.g., Provider and Member education programs that promote clinically appropriate and safe dispensing and use of Prescription Drugs). For purposes of this Agreement, administrative fees and service fees received by Anthem or PBM shall not be considered Drug Rebates.

d. If Employer terminates the pharmacy benefits portion of its Plan with Anthem at any time, then Anthem shall have the right to amend the Base Administrative Services Fee indicated in Section 3(A) of Schedule A.

ARTICLE 15 - INTER-PLAN ARRANGEMENTS

This Article is intentionally omitted and replaced by the Inter-Plan Arrangements Schedule.

ARTICLE 16 - CLAIMS LITIGATION

a. For purposes of Articles 16 and 17 of this Agreement, "Claims Litigation" means a demand asserted or litigation, proceedings or arbitration commenced, by a Member, Plan beneficiary or Network or non-Network

Provider, or any individual or entity working on any of their behalf ("Claimant(s)"), regardless of how pled or how asserted, where the Claimant seeks to recover monetary damages (including but not limited to actual, compensatory, punitive or other damages), equitable relief, declaratory relief, attorneys' fees, costs, expenses, or other relief, in connection with Anthem's alleged failure to properly handle a request for Covered Services or to pay for all or any portion of Covered Services, including any allegations related to the sufficiency of the amount paid for all or any portion of a Covered Service. References to "Employer" in this Article 16 shall mean Employer or Plan or both as appropriate given the context.

b. Anthem shall direct the defense of any Claims Litigation brought against Anthem. If Employer (in addition to Anthem) is also a named party in the Claims Litigation, Anthem shall direct the defense of the Claims Litigation and the Employer will cooperate in defending against the Claims Litigation. Employer will direct the defense of the Claims Litigation where Anthem is not a named party. Unless there is a conflict that is not waived, in any of the above scenarios, if Anthem's requests, Anthem and the Employer will enter a common interest and/or joint defense agreement to address the sharing of information and any other matters the Parties deem appropriate. Whether there is such a conflict or not, all other provisions of this Article 16 will continue to apply. Anthem shall provide notice of Claims Litigation to the Employer as soon as practicable; provided, however, that this notice obligation shall not apply to Claims Litigation brought by any Provider or to any Claims Litigation to which Employer is a named party.

c. For any Claims Litigation to which Anthem is a named party, Anthem will select and retain counsel for itself and, if Employer is also named, for the representation of Anthem and Employer contemplated by Article 16(b). If, at the outset or during such Claims Litigation, Employer and Anthem have a conflict of interest, the selected counsel shall represent Anthem only. Employer shall waive any conflict for such representation and retain separate counsel for Employer. Subject to Article 16(d), Employer will assume liability for payment of all reasonable attorneys' fees and costs incurred by Anthem and/or Employer in the defense of Claims Litigation.

d. If it is determined by the third-party decision maker in the Claims Litigation that Anthem failed to perform its responsibility to review and determine Claims for benefits under the Plan in a manner that is consistent with the standard of care in Article 17 of this Agreement, Anthem will assume liability for payment of its legal fees and costs.

e. Anthem is authorized to settle or compromise any Claims Litigation with the approval of Employer, which approval shall not be unreasonably withheld. Notwithstanding the above, settlements of reimbursement disputes brought by Providers do not require the approval of Employer.

f. Anthem is not an insurer of benefits under the Plan nor does it underwrite the risk or otherwise assume any risk for the payment of benefits under the Plan. Under all circumstances, Employer shall be liable to pay Plan benefits awarded or paid by settlement, judgment, or otherwise.

ARTICLE 17 - INDEMNIFICATION

Except for Claims Litigation, which is governed exclusively by Article 16 of this Agreement, Anthem and Employer shall each indemnify, defend and hold harmless the other Party, and its directors, officers, employees, agents and affiliates, from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) that are recovered in direct actions between the Parties or actions brought by a third party asserting liability for: (1) the indemnifying Party's or its subcontractor's gross negligence or willful misconduct in the performance of the obligations under this Agreement, and/or (2) the indemnifying Party's failure to provide information required under this Agreement or otherwise required by law that results in a sanction or penalty being assessed against the other Party, and/or (3) the indemnifying Party's or its subcontractor's breach of fiduciary duties under ERISA. The obligation to provide indemnification under this Agreement shall be contingent upon the Party seeking indemnification: (i) providing the indemnifying Party with prompt written notice of any claim for which indemnification is sought, (ii) allowing the indemnifying Party to control the defense and settlement of such claim; provided, however, that the indemnifying Party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified Party without that indemnified Party's prior written consent, which will not be unreasonably withheld; and, (iii) cooperating fully with the indemnifying Party in connection with such defense and settlement.

ARTICLE 18 - CHANGES IN BENEFITS BOOKLET AND AGREEMENT

a. Either Party reserves the right to propose changes to the provisions described in the Benefits Booklet by giving written notice to the other Party not less than 90 days prior to the start of an Agreement Period and such changes will be made to the Benefits Booklet as mutually agreed to in writing by the Parties. Either Party may also propose changes to the Benefits Booklet at a time other than the start of an Agreement Period and such changes will be made to the Benefits Booklet if mutually agreed to in writing by the Parties. Anthem's incorporation of the requested changes into the Benefits Booklet shall constitute Anthem's acceptance of the Employer's requested changes. If Anthem initiates the proposed changes and does not receive written notice from Employer prior to the effective date of the proposed changes that such changes are unacceptable, the changes shall be deemed approved by Employer and Anthem shall incorporate such changes into the Benefits Booklet.

b. If changes to the provisions of the Benefits Booklet are mandated as a result of a change to any applicable state or federal law, Anthem shall have the right to make such changes to the Benefits Booklet to comply with the law and shall provide written notice to Employer at least 30 days prior to the effective date of the change, unless the effective date specified in the law is earlier.

c. Anthem also reserves the right to change the Base Administrative Services Fee provided in Section 3(A) of Schedule A at a time other than the start of an Agreement Period upon the occurrence of one or more of the following events: (1) a change to the Plan benefits initiated by Employer that results in a substantial change in the services to be provided by Anthem; (2) a change in ownership as described in Article 3(h) of this Agreement; (3) a change in the total number of Members resulting in either an increase or decrease of 10% or more of the number of Members enrolled for coverage on the date the Base Administrative Services Fee was last modified; (4) a change in Employer contribution as described in Article 3(e) of this Agreement; (5) a change in nature of Employer's business resulting in a change in its designated Standard Industrial Classification ("SIC") code; or (6) a change in applicable law that results in a material increase in the cost or amount of administrative services from those currently being provided by Anthem under this Agreement. Anthem shall provide notice to Employer of the change in the Base Administrative Services Fee at least 60 days prior to the effective date of such change. If such change is unacceptable to Employer, either Party shall have the right to terminate this Agreement by giving written notice of termination to the other Party before the effective date of the change. If Employer accepts the proposed Base Administrative Services Fee, Anthem shall provide a revised Schedule A that will then become part of this Agreement without the necessity of securing Employer's signature on the Schedule.

d. In the event any action of any department, branch or bureau of the federal, state or local government is initiated or taken ("Action") against a Party to this Agreement and such Action materially and adversely affects that Party's performance of the obligations under this Agreement, the affected Party shall notify the other Party of the nature of the Action and provide copies of pertinent documents supporting the reason(s) for the Action. If a modification to the Agreement is needed as a result of the Action, the Parties shall meet within 30 days of the notice by the affected Party to the other Party and shall, in good faith, attempt to negotiate a modification to this Agreement that minimizes or eliminates the impact of the Action. If the Parties are unable to minimize or eliminate the impact of the Action, then either Party may terminate this Agreement by giving at least 90 days notice of termination. This Agreement may be terminated sooner if agreed to by the Parties or required by the government entity initiating or taking the Action.

e. No modification or change in any provision of this Agreement shall be effective unless and until approved in writing by an authorized representative of Anthem and evidenced by an amendment or new Schedule attached to this Agreement. If Anthem proposes such a modification or change, Anthem shall provide written notice to Employer at least thirty (30) days prior to the effective date of such change. The modification or change will be deemed accepted by Employer unless Anthem receives written notice from Employer prior to the effective date that such change is unacceptable. If Employer does not accept the proposed change, the Parties will meet and confer to reach agreement prior to implementation of such change.

ARTICLE 19 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE

a. Notwithstanding any other provision of this Article, this Agreement automatically terminates, without further notice or action, if Employer fails to pay or fund any amount due under this Agreement within 7 days of the date of Anthem's notice to the Employer of a delinquent amount owed. Notwithstanding the foregoing, in the event of a bona fide dispute regarding an Administrative Service Fee charge, Anthem shall not

terminate this Agreement on the basis of the alleged delinquency pending the resolution of such dispute if the Employer pays all undisputed amounts when due. Such termination shall be effective as of the last period for which full payment was made. In addition, this Agreement automatically terminates, without further notice or action, at the end of each Agreement Period unless Anthem offers to renew this Agreement and Employer accepts such offer of renewal pursuant to Article 6 of this Agreement. Upon termination of this Agreement, Employer shall remain liable for all payments due to Anthem under the terms of this Agreement. Notwithstanding the above, Anthem has the right to suspend performance of its obligations under this Agreement if full payment is not made by the Invoice Due Date. Anthem shall have no obligation to pay any Claims under the Agreement until all required payments have been paid in full.

b. If either Party fails to comply with any material duties and obligations under this Agreement other than payment of amounts due under this Agreement, the other Party shall have the right to: (1) terminate this Agreement by giving the non-compliant Party at least 60 days prior written notice of termination; or (2) upon written notice to the other Party, suspend performance of its obligations under this Agreement. Employer acknowledges and agrees that in the event it is the non-compliant Party, Anthem shall have no liability to any Member. Either Party, at its option, may allow the non-compliant Party to cure a breach of this Agreement and, upon acceptance in writing by that Party that a breach is cured, this Agreement may be reinstated retroactive to the date of the breach or suspension of performance. Notwithstanding any other provision of this Agreement, a Party may seek injunctive or other equitable relief from a court of competent jurisdiction should there be any unauthorized use or disclosure of Proprietary Information or Confidential Information by the other Party.

c. If there shall occur any change in the condition (financial or otherwise) of Employer or an Employer Affiliate that, in the reasonable opinion of Anthem, has a material adverse effect upon the validity, performance, or enforceability of this Agreement, on the financial condition or business operation of Employer (or Employer Affiliate), or on the ability of Employer to fulfill its obligations under this Agreement, then Anthem shall have the right to require Employer to provide adequate assurance of future performance, which may include a payment of a cash deposit, letter of credit, or other method of assurance acceptable to Anthem. Examples of such a change could include, but would not be limited to the actual, or Anthem's reasonable anticipation of: (1) any voluntary or involuntary case or proceedings under bankruptcy law with respect to Employer or an Employer Affiliate; (2) any receivership, liquidation, dissolution, reorganization or other similar case or proceeding with respect to Employer or an Employer Affiliate; (3) any appointment of a receiver, trustee, custodian, assignee, conservator or similar entity or official for Employer or an Employer Affiliate; or (4) any assignment for the benefit of creditors or sale of all or substantially all of Employer's assets or a key Employer Affiliate's assets.

Any deposit amount shall be paid to Anthem within 30 days of the request or in such shorter time as agreed to by the Parties. The deposit amount shall not be paid with Plan assets, shall not be funded in any part by Member contributions, and shall not be paid from any segregated fund or from funds in which the Plan or any Member has a beneficial interest. The deposit amount shall be the property of Anthem, may be held in Anthem's general account, may be subject to satisfy the claims of Anthem's general creditors, and does not govern or limit the benefits available under the terms of the Plan. At the termination of this Agreement and designated Claims Runout Period, if any, the deposit amount, net of any outstanding fees or Claims amounts payable to Anthem, shall be returned to Employer. Any deposit amount returned to Employer under this Article 19(c) shall not include interest. Neither Employer, the Plan, nor any Member shall have any beneficial or legal ownership interest in any deposit amount paid pursuant to this Section.

If such further assurance is required by Anthem, Anthem may, at any time after the date of notice to Employer of such requirement, suspend performance of its obligations under this Agreement until the date of receipt by Anthem of such adequate assurance without being liable to the Employer, the Plan or any Member for such suspension. If such adequate assurance is not received within 30 days of the request, Anthem may terminate this Agreement.

d. Subject to the provisions of Article 7 of this Agreement, if this Agreement terminates and Anthem makes payment of any Claim that would otherwise have been payable under the terms of this Agreement after the termination date, Employer shall be liable to reimburse Anthem for such Claim to the extent that the amounts have not already been paid by Employer. Employer also agrees to cooperate fully with Anthem in the coordination of pharmacy Claims with any successor pharmacy benefit manager.

e. Employer may terminate this Agreement at any time other than at the end of an Agreement Period by giving Anthem 60 days written notice of its intent to terminate.

f. In connection with the termination of this Agreement and upon Employer's request, Anthem shall provide reports that are part of Anthem's standard account reporting package at no extra charge. In no event shall Anthem be obligated to produce more than two sets of reports following the termination date of this Agreement. However Anthem shall have no obligation to provide the reports after the termination date of this Agreement if such termination is due to non-payment pursuant to Article 19(a) of this Agreement. In addition, Anthem shall also provide data extract files upon Employer's request for an additional fee mutually agreed to by the Parties.

ARTICLE 20 - LIMITATION ON ACTIONS AND GOVERNING LAW

a. No action by either Party alleging a breach of this Agreement may be commenced after the expiration of 3 years from the date on which the claim arose.

b. Except to the extent preempted by ERISA or any other applicable provisions of federal law, this Agreement shall be governed by, and shall be construed in accordance with the laws of Virginia but without giving effect to that state's rules governing conflict of laws.

ARTICLE 21 - NO WAIVER

No failure or delay by either Party to exercise any right or to enforce any obligation herein, and, no course of dealing between Employer and Anthem, shall operate as a waiver of such right or obligation or be construed as or constitute a waiver of the right to enforce or insist upon compliance with such right or obligation in the future. Any single or partial exercise of any right or failure to enforce any obligation shall not preclude any other or further exercise, or the right to exercise any other right or enforce any other obligation.

ARTICLE 22 - ASSIGNMENT AND SUBCONTRACTING

a. Unless it has first obtained the written consent of an officer of the other Party, neither Party may assign this Agreement to any other person. Notwithstanding the foregoing, Anthem may, with advance written notice to Employer, assign or otherwise transfer its rights and obligations hereunder, in whole or in part, to: (i) any affiliate of Anthem; or (ii) any entity surviving a transaction involving the merger, acquisition, consolidation, or reorganization of Anthem, or in which all or substantially all of Anthem's assets are sold. Additionally, Employer may, with advance written notice to Anthem, assign, delegate, or otherwise transfer its rights and obligations hereunder, in whole, to (i) any affiliate of Employer; or (ii) any entity surviving a transaction involving the merger, acquisition, consolidation or reorganization of Employer, or in which all or substantially all of Employer's assets are sold, provided that such affiliate or other assignee presents, in Anthem's opinion, an equivalent or better financial status and credit risk. Either Party is required to provide advance written notice under this provision only to the extent permissible under applicable law and the reasonable terms of the agreement(s) governing such merger, acquisition, consolidation, reorganization, or asset sale. If advance written notice is not allowed, notice shall be provided as soon as practicable. Upon receipt of notice of an assignment of this Agreement, the other Party may terminate this Agreement by providing the assigning Party with 30 days advance written notice of termination. Any assignee of rights or benefits under this Agreement shall be subject to all of the terms and provisions of this Agreement.

b. Either Party may subcontract any of its duties under this Agreement without the prior written consent of other Party; however, the Party subcontracting the services shall remain responsible for fulfilling its obligations under this Agreement.

ARTICLE 23 - NOTICES

a. Any notice or demand pursuant to Articles 19 and 22 of this Agreement shall be deemed sufficient when made in writing as follows: to Employer, by first class mail, personal delivery, or electronic mail or overnight delivery with confirmation capability, to its principal office shown upon the records of Anthem; to Anthem, by first class mail, personal delivery, electronic mail or overnight delivery with confirmation capability, to the designated Anthem sales representative.

b. A notice or demand shall be deemed to have been given as of the date of deposit in the United States mail with postage prepaid or, in the case of delivery other than by mail, on the date of actual delivery at the appropriate address.

c. Employer shall be obligated to provide all notices to Members as may be necessary to effectuate any change in or termination of the Agreement.

ARTICLE 24 - ADMINISTRATION

a. Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between Employer and Anthem, that Anthem is an independent corporation operating under a license with BCBSA permitting Anthem to use the Blue Cross and Blue Shield Service Marks in Virginia and that Anthem is not contracting as the agent of BCBSA. Employer further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to it for any of Anthem's obligations to Employer created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this Agreement.

b. Anthem is providing administrative services only with respect to the portion of the Plan described in the Benefits Booklet. Anthem has only the authority granted it pursuant to this Agreement. Anthem is not the insurer or underwriter of any portion of the Plan. Anthem has no responsibility or liability for funding benefits provided by the Plan, notwithstanding any advances that might be made by Anthem. Employer retains the ultimate responsibility and liability for the benefits and expenses incident to the Plan, including the applicable taxes that might be imposed relating to the Plan.

c. The Parties acknowledge that the portion of the Plan described in the Benefits Booklet is a self-funded plan and is not subject to state insurance laws or regulations.

d. Employer shall confirm that sufficient amounts are available to cover Claims payments, the monthly Administrative Services Fees, and other fees or charges.

ARTICLE 25 - ENTIRE AGREEMENT

a. The following documents will constitute the entire Agreement between the Parties: this Agreement, including any amendments and Schedules thereto, and the Benefits Booklet.

b. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

c. This Agreement supersedes any and all prior agreements between the Parties, whether written or oral, and other documents, if any, addressing the subject matter contained in this Agreement.

d. If any provision of this Agreement is held to be invalid, illegal or unenforceable in any respect under applicable law, order, judgment or settlement, such provision shall be excluded from the Agreement and the balance of this Agreement shall be interpreted as if such provision were so excluded and shall be enforceable in accordance with its terms.

ARTICLE 26 - DISPUTE RESOLUTION

This Article is intentionally omitted in its entirety.

ARTICLE 27 - MISCELLANEOUS

a. Employer and Anthem are separate legal entities. Anthem is strictly an independent contractor. Nothing contained in this Agreement shall cause either Party to be deemed a partner, member, agent or representative of the other Party, nor shall either Party have the expressed or implied right or authority to assume or create any obligation on behalf of or in the name of the other Party through its actions, omissions or representations.

b. Except as may be explicitly set forth in this Agreement, nothing herein shall be construed as an implied license by a Party to use the other Party's name, trademarks, domain names, or other intellectual property. Neither Party shall use the name, trademarks, domain names, or any other name or mark of the other Party in any press release, printed form, advertising or promotional materials or otherwise, without the prior

written consent of the other Party. In addition, Employer has no license to use the Blue Cross and/or Blue Shield trademarks or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Employer to use the Brands. Any references to the Brands made by Employer in its own materials are subject to prior review and approval by Anthem.

c. Nothing contained herein shall cause either Party to be deemed an agent for service of legal process for the other Party.

d. Anthem or an Anthem Affiliate may enter into business arrangements with certain Network Providers and Anthem may have financial interest in such Network Providers through direct ownership, partnership, joint venture or other arrangements. The business arrangements may provide practice management or other services to Network Providers that are designed to promote a more effective and cost-efficient health care delivery system that emphasizes continuous improvement and increased patient access to high quality, cost-effective health care. Because of its ownership or financial interests in Network Providers, Anthem may share in the Network Provider's profits or other revenue. Any revenue received by Anthem in connection with these business arrangements shall be retained by Anthem.

e. The Parties acknowledge that Anthem, in making decisions regarding the scope of coverage of services under the Benefits Booklet, is not engaged in the practice of medicine. Providers are not restricted in exercising their independent medical judgment by contract or otherwise and do not act on behalf of, or as agents for, Anthem or the Plan.

f. In addition to any other provision providing for survival upon termination of this Agreement, the Parties' rights and obligations under Articles 10, 11, 12, 13, 16, 17, 19, 24, 25(a) and 25(c) shall survive the termination of this Agreement for any reason.

g. Each Party shall comply with all laws and regulations applicable to their respective duties and obligations assumed under this Agreement.

h. Anthem and Employer agree to the performance standards set forth in Schedule C Performance Guarantees Schedule.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by affixing the signatures of duly authorized officers.

Owens & Minor Medical, Inc.	HealthKeepers, Inc. and Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

SCHEDULE A
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
OWENS & MINOR MEDICAL, INC.

This Schedule A shall govern the Agreement Period from June 1, 2017 through December 31, 2018. For purposes of this Agreement Period, this Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms and conditions of the Agreement including any prior Schedules, and this Schedule A, the terms and conditions of this Schedule A shall control.

Section 1. Effective Date and Renewal Notice

This Agreement Period shall be from 12:01 a.m. June 1, 2017 to the end of the day of December 31, 2018.

Paid Claims shall be processed pursuant to the terms of this Agreement when incurred and paid as follows:

Incurred from June 1, 2017 through December 31, 2018 and
Paid from June 1, 2017 through December 31, 2018.

Anthem shall provide any offer to renew this Agreement at least 120 days prior to the end of an Agreement Period.

Section 2. Broker or Consultant Base Compensation

Medical

Broker or Consultant Fee is $3.47 per Subscriber per month. Upon receipt of payment from Employer, Anthem shall remit payment to the broker or consultant designated by Employer.

Section 3. Administrative Services Fees

A. Base Administrative Services Fee

June 1, 2017 through May 31, 2018:	Composite	$ 35.41 per Subscriber per month
June 1, 2018 through December 31, 2018:	Composite	$ 36.55 per Subscriber per month

Prescription Drug Rebates: Anthem will pay to Employer 100% of the Drug Rebates collected from PBM and attributable to Employer's Plan subject to Anthem's timely receipt of payment and accompanying data from PBM. On a quarterly basis, Anthem shall credit Employer the Drug Rebates it has collected from PBM. Anthem shall have the right to collect from Employer any rebate amount that Anthem is required to pay PBM as a result of a pharmaceutical manufacturer audit or for any other reason. Anthem shall continue to provide Employer its share of the Drug Rebates under this provision until the termination of this Agreement and any applicable Claims Runout period. Anthem shall provide a final report of the Drug Rebates received attributable to Employer's Plan after the end of any applicable Claims Runout period.

Change to Base Administrative Services Fees. In addition to the provisions in Article 18(c), Anthem reserves the right to change the Base Administrative Services Fees upon the occurrence of any of the following events:

- Employer's Member to Subscriber ratio is not within +/-5% of 1.93
- Anthem is not the sole third party administrator for medical benefits under Employer's Plan
- Employer's enrollment is not within +/-10% of 4,042 Subscribers
- Employer moves any of the Plan Benefits administered under this Agreement to another third party administrator or public or private exchanges

Multi-year Agreements: Anthem has the right to charge a fee to Employer if Employer terminates the pharmacy benefits administered by Anthem prior to the end of the multi-year Agreement Period contained in this Agreement. If Employer terminates the pharmacy benefits administered by Anthem prior to the end of the multi-year Agreement Period, Employer shall pay to Anthem upon receipt of an invoice:

$1.00 Per Subscriber per month multiplied by the monthly average number of Subscribers enrolled in the Plan for the time period that this multi-year Agreement remained in effect multiplied by the number of months remaining in the multi-year Agreement after Employer's termination of the Agreement.

Pharmacy Benefits Administrative Services Fee. Administrative Services Fees shall also include a fee that will be charged monthly for services related to pharmacy benefits management including, but not limited to, pharmacy mail services, clinical services, and customer services. Such fee is included in the Base Administrative Services Fees described in Section 3(A) of this Schedule A.

Article 3(a) Retroactive Adjustments to Enrollment.

Anthem shall credit Administrative Services Fees for each retroactive deletion up to a maximum of 60 days and shall charge Administrative Services Fees for each retroactive addition up to a maximum of 60 days.

B. Health and Wellness Program Fees

Integrated Imaging Bundle	$1.28 per Subscriber per month
Mobile Health Consumer	$0.65 per Subscriber Per Month

C. Other Fees or Credits

Fee for Subrogation Services. The charge to Employer is 25% of gross subrogation recovery, or, if outside counsel is retained, 15% of the net recovery after a deduction for outside counsel fees.

Fee for Provider Audit Performed by External Vendors. The charge to Employer is 25% of the amount recovered from Vendor audits of Provider activity, including but not limited to credit balance, hospital bill audits, DRG readmissions and high-cost drug audits.

Fee for Overpayment Identification Provided by External Vendors. The charge to Employer is 25% of the amount recovered from review of Claims and membership data to identify overpayments, including but not limited to COB, duplicates, contract compliance and eligibility.

Fee for Collection Services Provided by External Vendors. The charge to Employer is 25% of the amount recovered by a Vendor in collecting receivables.

Fee for Independent Claims Review: $550.00 per independent review

Traditional Network Savings Fee. Employer agrees to pay an additional amount based on the difference between Billed Charges for Covered Services and the Traditional Provider Negotiated Amount. The "Traditional Provider Negotiated Amount" is the amount Anthem, an Anthem Affiliate and/or Host Blue is contractually obligated to pay a Traditional Provider under a negotiated fee schedule, before application of Member cost-share amounts, such as deductibles, copayments and coinsurance. Claims submitted by a Provider affiliated with the Employer shall not be included in this calculation. Prescription Drug Claims, Claims paid on a capitated basis and Payment Innovation Program payments are excluded from the fee calculation. This fee applies to certain Providers who are paid by Anthem, an Anthem Affiliate and/or Host Blue according to a Traditional Network fee schedule ("Traditional Provider"). The Traditional Network Savings Fee is equal to 50% per Claim.

Non-Network Savings Fee. When Anthem forwards a non-Network Provider Claim to Vendor to negotiate with the non-Network Provider, the Employer will pay a fee equal to 50% of the difference between the non-Network Provider's Billed Charges and the amount Anthem uses to calculate Plan liability for the Covered Service (the "Plan Liability Amount"). In the case of facility-based Provider Claims, Plan Liability Amount will be based on the negotiated rate; if negotiations are not successful, the Plan Liability Amount shall be determined using Vendor's Data iSight tool. In the case of professional Provider Claims, Plan Liability Amount will be based upon Vendor's negotiated rate, if applicable (in the absence of successfully negotiated Claims, there will be no fee charged as the amount will be determined by the local Blue plan). These Claims will not be included in any Performance Guarantee calculations.

Medical Drug Rebates: Anthem shall retain rebates it receives directly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by Anthem and covered under the medical benefit portion of the Plan(s) ("Medical Drug Rebates") for its own use and as reasonable compensation for its services.

Third Party Stop Loss Reporting Fee: Employer will pay a fee of $1.00 per Subscriber per month for generation of reports delivered to an external stop loss carrier. Confidentiality Agreements must be completed with the Employer and third party stop loss carrier prior to files being released.

Fee for Ad Hoc Reports. Anthem shall provide, on an annual basis, up to 20 hours of time needed to generate custom or ad hoc reports at no additional charge. The charge to Employer beyond 20 hours per year is $150.00 per hour for time needed to generate custom or ad hoc reports.

Fee for Electronic Data Feeds to an Outside Vendor. Anthem shall provide, on an annual basis, up to 12 electronic data feeds to an outside vendor in Anthem's standard format. The charge to Employer is $1,000.00 for each additional feed.

Universal Credit. Anthem shall provide a credit totaling $18 per Subscriber enrolled on June 1, 2017 to Employer for use from June 1, 2017 through December 31, 2019 and forfeited if not used within 36 months following the effective date. Services from a vendor that is a direct competitor of Anthem are not eligible for reimbursement. Anthem will not reimburse Employer's vendors directly.

The credit can be used for the following purposes:

- Custom communication services provided by either Anthem or an outside vendor;
- Pre-implementation audit equal to actual billed charges;
- Implementation expenses;
- Claims audit equal to actual billed charges*;
- Clinical audit equal to actual billed charges*;
- Wellness programs purchased by Employer from Anthem; or
- Additional reporting or data feeds equal to the actual billed charges.

Personnel expenses, programming expenses and travel are not reimbursable. The Employer acknowledges and agrees that Anthem will report the payment or credit where required by law to do so.

Employee Assistance Program (EAP):

Basic Program (3 Face-to-Face Counseling Visits) $1.05 per Subscriber Per Month

Section 4. Paid Claims, Billing Cycle and Payment Method

A. Paid Claims

Paid Claims are described in Article 1-Paid Claims Definition of the Agreement.

B. Billing Cycle

Weekly

Anthem shall notify Employer of the amount due to Anthem as a result of Claims processed and paid by Anthem according to the billing cycle described above. The actual date of notification of Paid Claims and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

C. Payment Method

ACH Demand Debit Reimbursement for Paid Claims. Anthem will initiate an ACH demand debit transaction that will withdraw the amount due from a designated Employer bank account no later than three (3) business days following the Invoice Due Date, however, if the Invoice Due Date falls on either a banking holiday, a Saturday or a Sunday, the withdrawal shall be made on the following banking day.

Section 5. Administrative Services Fee Billing Cycle and Payment Method

A. Billing Cycle

Monthly List Bill (pay as billed)

Anthem shall notify Employer of the amount due to Anthem pursuant to Section 3 of Schedule A according to the billing cycle described above. The actual date of notification of amounts due and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

B. Payment Method

ACH Demand Debit Reimbursement. Anthem will initiate an ACH demand debit transaction that will withdraw the amount due from a designated Employer bank account no later than three (3) business days following the Invoice Due Date, however, if the Invoice Due Date falls on either a banking holiday, a Saturday or a Sunday, the withdrawal shall be made on the following banking day.

Section 6. Claims Runout Services

A. Claims Runout Period

Claims Runout Period shall be for the 12 months following the date of termination of this Agreement.

B. Claims Runout Administrative Services Fees

Medical:

Claims Runout Administrative Services Fee will be equal to 6% of Claims processed and paid by Anthem or through Inter-Plan Arrangements if Employer terminates prior to 3 years from the effective date of the Agreement Period. A Claims Runout Administration Services Fee will not be charged if the Employer terminates at least 3 years after the effective date of the Agreement Period.

Section 7. Inter-Plan Arrangements:

All Inter-Plan Arrangement-related fees, including any Access Fees paid to Host Blues, the Administrative Expense Allowance ("AEA") Fee and any Negotiated Arrangement fees are included in Anthem's Base Administrative Services Fee. Other Inter-Plan Arrangement-related fees included in the Base Administrative Services Fee include the Central Financial Agency Fee, ITS Transaction Fee, Toll-Free Number Fee and, if applicable, Blue Cross Blue Shield Global Core Program Fees. If Employer requests printed Provider directories attributable to a Host Blue's service area, the fee that will be charged is dependent upon page length, number ordered and will include shipping, taxes and system maintenance costs.

Blue Cross Blue Shield Global Core Fees – Included in Base Administrative Services Fee.

Section 8. Other Amendments. The Administrative Services Agreement is otherwise amended as follows:

Not Applicable.

SCHEDULE B
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
OWENS & MINOR MEDICAL, INC.

This Schedule B shall govern the Agreement Period from June 1, 2017 through December 31, 2018. For purposes of this Agreement Period, this Schedule B shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule B, the terms of this Schedule B shall control.

The following is a list of services that Anthem will provide under this Agreement for the Base Administrative Services Fee listed in Section 3(A) of Schedule A. These services will be furnished to Employer in a manner consistent with Anthem's standard policies and procedures for self-funded plans. Anthem may also offer services to Employer that have an additional fee. If Employer has purchased such services, those services and any additional fees are also listed in Schedule A.

SERVICES INCLUDED IN THE BASE ADMINISTRATIVE SERVICES FEE IN SECTION 3A OF SCHEDULE A

Management Services

- Anthem's Benefits and administration as described in this paragraph:

  - Anthem definitions, and exclusions
  - Employer-specific benefits and exclusions
  - Anthem complaint and appeals process (One mandatory level of appeal, one voluntary level of appeal)
  - Claims incurred and paid as provided in Schedule A
  - Accumulation toward plan maximums beginning at zero on effective date
  - Anthem Claim forms
  - ID card
  - Explanation of Benefits (Non-customized)

- Acceptance of electronic submission of eligibility information in HIPAA-compliant format

- Preparation of Benefits Booklet (accessible via internet)

- Information for ERISA 5500

- Account reporting - standard data reports

- Billing and banking services

- Plan Design consultation

- Employer eServices

  - Add and delete Members
  - Download administrative forms
  - View Member Benefits and request ID cards
  - View eligibility
  - View Claim status and detail

- Responsible Reporting Entity for the Plan

- Information for preparation of SBC

Claims and Customer Services

- Claims processing services
- Coordination of Benefits
- Recovery services performed internally by Anthem
- Medicare crossover processing
- Employer customer service, standard business hours
- Member customer service, standard business hours
- 1099s prepared and delivered to Providers
- Residency-based assessments and/or surcharges and other legislative reporting requirements
- Member eServices
- Member identity theft and credit monitoring and identity repair
- Open enrollment meeting support
- Women's Health and Cancer Rights Act notices

Prescription Benefit Services

- Home delivery pharmacy
- Specialty Pharmacy Services
- Prescription eServices
  - Pharmacy locator
  - Online formulary
- Point of sale claims processing
- Home delivery claims processing
- Home delivery call center with toll free number
- Home delivery regular shipping and handling
- Standard management reports
- Ad hoc reports (subject to additional programming charge if required)
- Concurrent Drug Utilization Review (DUR) programs
- Retrospective DURs
- Administrative override (i.e., vacation, lost, stolen or spilled medications)
- Clinical review
- Pharmacy help desk with toll free number
- Pharmacy audits (desk and onsite; routine, in depth or focused)

Care Management

- Health Care Management

  - Referrals
  - Utilization management
  - Case management
  - Anthem Medical Policy

- SpecialOffers

- HealthCare Advisor

- Care Comparison (where available)

- Transplant services - Blues Distinction

- Healthy Solutions Newsletter (available online)

- MyHealth (Member Portal)

  - Electronic Health Risk Assessment
  - Personal Health Record
  - Online Communities
  - Member Alerts

- Health and Wellness Services (PPO Plan)

  - ConditionCare

    - Asthma
    - Pulmonary disease
    - Congestive heart failure
    - Coronary artery disease
    - Diabetes

  - Future Moms Maternity Program with Mailings

  - ComplexCare

  - 24/7 NurseLine

  - MyHealth Advantage -- Gold Level

  - Healthy Lifestyles Online

  - LiveHealth Online

  - Emergency Room Utilization Management (ERUMI)/Quick Care Options (QCO)

  - Oncology Solution

  - Utilization Review and Case Management (UR-CM)

Networks

- Access to networks

  - Provider Network
  - Mental Health/Substance Abuse Network
  - Coronary Services Network
  - Human Organ and Tissue Transplant Network
  - Complex and Rare Cancer Network
  - Bariatric Surgery Network

- Network Management

- Online Provider directory

- Inter-Plan Arrangements

SCHEDULE C
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
OWENS & MINOR MEDICAL, INC.

This Schedule C provides certain guarantees pertaining to Anthem's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for the period from June 1, 2017 through December 31, 2018, unless otherwise specified herein (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Schedule C and made a part of this Schedule C. This Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule C, the terms of this Schedule C shall control. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Attachments to this Schedule C, the terms of the Attachments to this Schedule C shall control. These Performance Guarantees are guaranteed upon offer and acceptance of renewal.

Section 1. General Conditions

A. The Performance Guarantees described in the Attachments to this Schedule C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:

1. Performance Category. The term Performance Category describes the general type of Performance Guarantee.

2. Reporting Period. The term Reporting Period refers to how often Anthem will report on its performance under a Performance Guarantee.

3. Measurement Period. The term Measurement Period is the period of time under which Anthem's performance is measured, which may be the same as or differ from the period of time equal to the Performance Period.

4. Penalty Calculation. The term Penalty Calculation generally refers to how Anthem's payment will be calculated, in the event Anthem does not meet the target(s) specified under the Performance Guarantee.

5. Amount at Risk. The term Amount at Risk means the amount Anthem may pay if it fails to meet the target(s) specified under the Performance Guarantee.

B. Anthem shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Schedule C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Anthem shall be based on Anthem's then current measurement and calculation methodology, which shall be available to Employer upon request.

C. Any audits performed by Anthem to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.

D. If the Parties do not have an executed Agreement, Anthem shall have no obligation to make payment under these Performance Guarantees.

E. Unless otherwise specified in the Attachments to this Schedule C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by Anthem or its Vendors.

F. If Employer terminates the Agreement between the Parties prior to the end of the Performance Period, or if the Agreement is terminated for non-payment, then Employer shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.

G. Anthem reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Schedule C upon the occurrence, in Anthem's determination, of either:

1. a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee; or

2. an increase or decrease of 10% or more of the number of Subscribers that were enrolled for coverage on the latter of the effective date or renewal date of this Agreement.

Should there be a change in occurrence as indicated above and these changes negatively impact Anthem's ability to meet the Performance Guarantees, Anthem shall have the right to modify the Performance Guarantees contained in the Attachments.

H. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Schedule C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem, or its Vendors, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

I. Some Performance Guarantees measure and compare year to year performance. The term Baseline Period refers to the equivalent time period preceding the Measurement Period.

J. As determined by Anthem, Performance Guarantees may be measured using either aggregated data or Employer-specific Data. The term Employer-specific Data means the data associated with Employer's Plan that has not been aggregated with other employer data. Performance Guarantees will specify if Employer-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.

K. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if Employer participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.

Section 2. Payment

A. If Anthem fails to meet any of the obligations specifically described in a Performance Guarantee, Anthem shall pay Employer the amount set forth in the Attachment describing the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees, which will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the above, Anthem has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Schedule C against any amounts owed by Employer to Anthem under: (1) any Performance Guarantees contained in the Attachments to this Schedule C; (2) the Agreement; or, (3) any applicable Stop Loss Policy.

C. Notwithstanding the foregoing, Anthem's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the Agreement in this Schedule C, and the Attachments, including providing Anthem with the information or data required by Anthem in the Attachments. Anthem shall not be obligated to make payment under a Performance Guarantee if Employer or Employer's vendor's action or inaction adversely impacts Anthem's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, which expressly includes but is not limited to Employer or its vendor's failure to timely provide Anthem with accurate and complete data or information in the form and format expressly required by Anthem.

D. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the actual annual enrollment during the Measurement Period.

Section 3. Performance Guarantee Amounts at Risk

A. The Amount(s) at Risk under the Performance Guarantees is/are:

- Implementation Guarantee: 5% of the Base Medical Administrative Services Fees listed in Section 3(A) of Schedule A for the PPO Plan.
- Operations Guarantee: 15% of the Base Medical Administrative Services Fees listed in Section 3(A) of Schedule A for the PPO Plan.
- Financial Guarantee: 30% of the Base Medical Administrative Services Fees listed in Section 3(A) of Schedule A for the PPO Plan.
- Integrated Imaging Guarantee: 20% of the Integrated Imaging Fees listed in Section 3(B) of Schedule A for the PPO Plan.
- EAP Guarantee: 20% of the EAP Fees listed in Section 3(C) of Schedule A for the PPO Plan.
- Pharmacy Guarantees: 15% of the Pharmacy Administration Fees listed in Section 3(A) of Schedule A for the PPO Plan.

ATTACHMENT TO SCHEDULE C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
OWENS & MINOR MEDICAL, INC.

Operation Performance Guarantees

This Attachment is made part of Schedule C and will be effective for the Performance Period from June 1, 2017 through December 31, 2018. This Attachment is intended to supplement and amend the Agreement between the Parties.

Additional Terms and Conditions:

- For purposes of imposing penalties, measurement shall not begin until the start of the fourth month of the initial Agreement period for the following measures: Claims Timeliness, Claims Financial Accuracy, Claims Accuracy, Average Speed of Answer, Call Abandonment Rate, and First Call Resolution
- Performance will be based on the results of a designated service team/business unit assigned to Employer, unless the guarantee is noted as measured with Employer-specific Data.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Implementation	6/1/2017-12/31/2018 2.5% of Base Admin. Services Fees	A minimum of 95% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties. The implementation plan will be developed by Anthem and will contain tasks to be completed by Employer and/or Anthem and a timeframe for completion of each task. The implementation plan will also contain Measurement Periods specific to each task. Anthem's payment under this Guarantee is conditioned upon Employer's completion of all designated tasks by the dates specified in the implementation plan. This will be measured with Employer-specific Data.	Result 95.0% or Greater 90.0% to 94.9% 85.0% to 89.9% Less than 85.0%	Penalty None 25% 50% 100%	**Measurement Period** Defined in Implementation Plan **Reporting Period** 60 calendar days following the end of the implementation period
Implementation Survey	6/1/2017-12/31/2018 2.5% of Base Admin. Services Fees	A minimum average score of 3.0 will be attained on the Implementation Survey. Anthem will prepare and send an Implementation Survey to Employer. Anthem will only consider survey results received within 30 calendar days from the delivery of the survey to the Employer. This will be measured with Employer-specific Data.	Average Number of Points 3.0 or Greater 2.5 to 2.9 2.0 to 2.5 Less than 2.0	Penalty None 25% 50% 100%	**Measurement Period** Annual **Reporting Period** 60 calendar days following Anthem's receipt of the survey
Claims Timeliness (14 Calendar Days)	2.0% of Base Admin. Services Fees	A minimum of 90% of Non-investigated medical Claims will be processed timely. Non-investigated Claims are defined as medical Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been finalized within 14 calendar days of receipt. This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	Result 90.0% or Greater 87.5% to 89.9% 85.0% to 87.4% Less than 85.0%	Penalty None 25% 50% 100%	**Measurement Period** Annual beginning with the start of the fourth month of the initial Agreement Period **Reporting Period** Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Claim Timeliness (30 Calendar Days)	2.0% of Base Admin. Services Fees	A minimum of 98% of Non-investigated medical Claims will be processed timely. Non-investigated medical Claims are defined as Claims that process through the system without the need to obtain additional information from the Provider, Subscriber, or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been finalized within 30 calendar days of receipt. This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	Result 98.0% or Greater 95.0% to 97.9% 92.0% to 94.9% Less than 92.0%	Penalty None 25% 50% 100%	**Measurement Period** Annual beginning with the start of the fourth month of the initial Agreement Period **Reporting Period** Annual
Claims Financial Accuracy	1.0% of Base Admin. Services Fees	A minimum of 99% of medical Claim dollars will be processed accurately. This Guarantee will be calculated based on the total dollar amount of audited medical Claims paid correctly divided by the total dollar amount of audited medical Paid Claims. The calculation of this Guarantee includes both underpayments and overpayments. The calculation of this Guarantee does not include Claim adjustments or Claims in any quarter in which an Employer requests changes to Plan benefits, until all such changes have been implemented.	Result 99.0% or Greater 98.0% to 98.9% 97.0% to 97.9% Less than 97.0%	Penalty None 25% 50% 100%	**Measurement Period** Annual beginning with the start of the fourth month of the initial Agreement Period **Reporting Period** Annual
Claims Accuracy	1.0% of Base Admin. Services Fees	A minimum of 97% of medical Claims will be paid or denied correctly. This Guarantee will be calculated based on the number of audited medical Claims paid and denied correctly divided by the total number of audited medical Claims paid and denied. The calculation of this Guarantee excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.	Result 97.0% or Greater 96.0% to 96.9% 95.0% to 95.9% Less than 95.0%	Penalty None 25% 50% 100%	**Measurement Period** Annual beginning with the start of the fourth month of the initial Agreement Period **Reporting Period** Annual
Open Enrollment ID Card Issuance	1.0% of Base Admin. Services Fees	100% of ID cards will be mailed to Open Enrollment participants no later than the Employer's effective date provided that Anthem receives an accurate eligibility file. An Accurate Eligibility File is defined as (1) an electronic eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem no later than 30 calendar days prior to the Employer's effective date; and, (3) contains an error rate of less than 1%. This will be measured with Employer-specific Data.	Result 100% 98.5% to 99.9% 97.0% to 98.4% Less than 97.0%	Penalty None $100 per ID Card not to exceed 25% of amount at risk for this measure 50% 100%	**Measurement Period** Employer's effective date **Reporting Period** 60 calendar days following the Employer's effective date

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Ongoing ID Cards Issuance	1.0% of Base Admin. Services Fees	A minimum of 99% of ongoing ID cards will be mailed to Members within 10 business days of Anthem's processing of an accurate eligibility file. An Accurate Eligibility File is defined as: (1) an eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem outside of an open enrollment period; and, (3) contains an error rate of less than 1%. This Guarantee will be calculated based on the total number of ongoing ID cards mailed to Members within the timeframe set forth above divided by the total number of Members eligible to receive ongoing ID cards. This will be measured with Employer-specific Data.	Result / Penalty 99.0% or Greater: None 97.5% to 98.9%: 25% 96.0% to 97.4%: 50% Less than 96.0%: 100%	**Measurement Period** Annual **Reporting Period** Annual
Average Speed to Answer	1.0% of Base Admin. Services Fees	The average speed to answer (ASA) will be 30 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR) or an interactive voice response (IVR) unit. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system.	Result / Penalty 30 seconds or less: None 30 to 35 seconds: 25% 35 to 39 seconds: 50% 40 or more seconds: 100%	**Measurement Period** Annual beginning with the start of the fourth month of the initial Agreement Period **Reporting Period** Annual
Call Abandonment Rate	1.0% of Base Admin. Services Fees	A maximum of 3.0% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. Calls that are abandoned in less than 5 seconds will not be included in this calculation.	Result / Penalty 3.0% or Less: None 3.1% to 3.5%: 25% 3.6% to 4.0%: 50% 4.00% or Greater: 100%	**Measurement Period** Annual beginning with the start of the fourth month of the initial Agreement Period **Reporting Period** Annual
First Call Resolution	1.0% of Base Admin. Services Fees	A minimum of 85% of member calls will be resolved during the initial contact with no further follow up required. First Call Resolution is defined as member callers receiving a response to their inquiry during an initial contact with no further follow-up required. This Guarantee will be calculated based on the total number of members who receive a First Call Resolution divided by the total number of calls received into the customer service telephone system.	Result / Penalty 85.0% or Greater: None 82.5% to 84.9%: 25% 80.0% to 82.4%: 50% Less than 80.0%: 100%	**Measurement Period** Annual beginning with the start of the fourth month of the initial Agreement Period **Reporting Period** Annual
Member Satisfaction	1.0% of Base Admin. Services Fees	A minimum average score of 90% will be attained on the service skills component of the member satisfaction survey. The survey is conducted within 48 hours of a member calling a customer service representative (CSR). Each member caller is asked to rate the CSR on 5 attributes using a 5 point scale. The response is scored based on the total number of attributes that a member caller rates as positive divided by the number of attributes for which the member caller provides an answer (Member Score). This Guarantee will be calculated by determining the average of all Member Scores.	Result / Penalty 90.0% or Greater: None 84.5% to 89.9%: 25% 80.0% to 84.4%: 50% Less than 80.0%: 100%	**Measurement Period** Annual **Reporting Period** Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Management Reports	1.0% of Base Admin. Services Fees	Standard automated reports will be made available to Employer by no later than 25 calendar days following the end of the month. The reports will include financial, utilization and clinical information. This will be measured with Employer-specific Data.	Result	Penalty	**Measurement Period** Annual **Reporting Period** Annual
			Reports are late 1 month	None	
			Reports are late 2 months	25%	
			Reports are late 3 or more months	100%	
Account Management Satisfaction	1.0% of Base Admin. Services Fees	A minimum average score of 3.0 will be attained on the Account Management Satisfaction Survey (AMSS). A minimum of 3 responses per Employer to the AMSS is required to base the score on Employer-specific responses only. If 3 responses are received from the Employer, an average score is calculated by adding the scores from each respondent divided by the total number of Employer respondents. If fewer than 3 responses are received, the score will be calculated as follows: 2 Employer responses: 2/3 of the score will be based on Employer-specific AMSS results and 1/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team. 1 Employer- response: 1/3 of the score will be based on Employer-specific AMSS results and 2/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team. 0 Employer responses: The score will be based on the aggregate score of all AMSS results received by the Account Management Team.	Result	Penalty	**Measurement Period** Annual **Reporting Period** Annual
			3.0 or higher	None	
			2.5 to 2.9	25%	
			2.0 to 2.4	50%	
			Less than 2.0	100%	
AHG Engagement by Customer Service	1% of Base Admin. Services Fees	A minimum of 85% of Eligible Contacts will have Member Engagement. Member Engagement is defined as coaching, education or Member direction from an AHG representative. This Guarantee will be calculated based on the number of Eligible Contacts with Member Engagement divided by the total number of contacts eligible for Member Engagement. Eligible Contacts include mobile chat, portal click-to-chat and phone contacts with an AHG representative. This will be measured with Employer-specific Data.	Result	Penalty	**Measurement Period** Annual **Reporting Period** Annual
			85% or Greater	None	
			83% - 84.9%	25%	
			81% - 82.9%	50%	
			79% - 80.9%	75%	
			Less than 79%	100%	

ATTACHMENT TO SCHEDULE C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
OWENS & MINOR MEDICAL, INC.

Network Guarantees

This Attachment to Schedule C Performance Guarantees is made part of Schedule C, shall be effective for the Performance Period from June 1, 2017 through May 31, 2018 and is intended to supplement and amend the Agreement between the Parties.

Additional Terms and Conditions:

- This Guarantee applies to following time periods: (Measurement Period)
  - Claims Incurred from June 1, 2017 through December 31, 2018 and Paid from June 1, 2017 and through December 31, 2018.
- This Guarantee excludes the total Claims Charges for any Member that exceeds $250,000 in paid claims in the Measurement Period.
- This guarantee replaces in previous financial guarantees presented. Discount guarantees cannot be offered alongside Trend Guarantees.
- Anthem has the right in its sole and reasonable discretion to modify or terminate this Guarantee if any of the following conditions occur:
  - Anthem is no longer the sole administrator for Employer's Plan.
  - Employer fails to maintain at least an average enrollment of 4,038 Subscribers.
  - The geographic distribution of Subscribers changes by more than 5% in any state or 10% in total from the Employer census provided for purposes of establishing this Guarantee.
- As previously mentioned, a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Network Provider Discount	30% of Base Admin. Services Fees	A minimum Network Provider Discount of 57%. This Guarantee excludes the total Claims Charges for any Member that exceeds $250,000 in paid claims in the Measurement Period. Eligible Claim Charges are defined as charges for Covered Services provided to Members enrolled in PPO Plans. Eligible Claim Charges will be based on Anthem primary Claims only and will not include charges related to Prescription Drug Claims, Inter-Plan Program fees, state surcharges, Anthem Provider payment innovation programs or services rendered outside the United States. Allowed Amount is defined as the amount paid by Anthem to PPO Network Providers on Eligible Claim Charges plus any Member Cost Shares. This Guarantee will be calculated by dividing the PPO Network Provider Allowed Amount by the PPO Network Provider Eligible Claim Charges. The resulting percentage shall be subtracted from 100% to determine the Network Provider Discount. This Guarantee will be calculated by dividing the PPO Network Provider Eligible Claim Charges less the Allowed Amount by the PPO Network Provider Eligible Claim Charges less Member cost shares. Anthem has the right in its sole discretion to modify or terminate this Guarantee if any of the following conditions occur: • Anthem is no longer the sole administrator for Employer's Plan	**Result**	**Penalty**	**Measurement Period** Annual* *This period applies to Claims incurred from June 1, 2017 through May 31, 2018 and Paid from June 1, 2017 and through August 31,2018. **Reporting Period** Annual
			57.0% or Greater	None	
			56.0% to 56.9%	25%	
			55.0% to 55.9%	50%	
			54.0% to 54.9%	75%	
			Less than 54.0%	100%	

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
		• Employer fails to maintain at least an average enrollment of 4,038 Subscribers. • The geographic distribution of Subscribers changes by more than 5% in any state or 10% in total from the Employer census provided for purposes of establishing this Guarantee. Only Claims submitted to a Blue Cross and/or Blue Shield licensee for processing and adjudication shall be considered for purposes of this Discount Guarantee. This will be measured with Employer-specific Data.		

ATTACHMENT TO SCHEDULE C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
OWENS & MINOR MEDICAL, INC.

Integrated Imaging Management Program

This Attachment to Schedule C Performance Guarantees is made part of Schedule C, shall be effective for the Performance Period from June 1, 2017 through December 31, 2018 and is intended to supplement and amend the Agreement between the Parties.

Additional Terms and Conditions

- Employer will communicate with its employees about the Integrated Imaging Program using marketing materials provided by Anthem.
- Unless otherwise provided herein, Anthem's Integrated Imaging Program includes high tech imaging services assigned at Anthem's discretion and include services such as CT, MRI, PET, nuclear cardiology, echocardiography, arterial ultrasound, cardiac catheterization and coronary intervention.
- Employer will support the clinical appropriateness decisions and cost/quality initiatives made by Anthem.
- Identified Members are Members who are identified by Anthem as appropriate for inclusion in the measured population, the selection criteria for which may be modified from time to time.
- A Member Redirected Service is an authorization for an imaging service (CT or MRI) provided at a location that is high quality and overall comparable or lower cost than the location originally requested by the ordering Provider.
- Member Redirected Guidance is defined as information provided by Anthem regarding options for imaging services (CT or MRI) at locations that are high quality and overall comparable or lower cost than the location originally requested by the ordering Provider.
- Standard minimum enrolled Members required: 5,000 non-Medicare primary Members.
- Members who are Medicare-primary are not eligible for inclusion in calculations related to these Performance Guarantees.
- Employer shall provide the historical eligibility information and the historical medical and Prescription Drug Claims in the form and for the time frame required by Anthem followed by monthly refreshes of Claims and Prescription Drug data from third party payers other than Anthem, if needed. All data must be materially complete and in the agreed upon format. Failure by Employer to provide any data in the time frame and format required by Anthem will nullify the applicable Performance Guarantee.
- Anthem reserves the right to revise Performance Guarantees to reflect modifications and advances in medical standards and practices when such standards and practices become generally accepted.
- Where the Amount at Risk for any Performance Guarantee provided below is based on a Per Subscriber Per Month (PSPM) basis, said Performance Guarantees shall be calculated by multiplying the PSPM amount by the actual enrollment during the Agreement Period.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Member Redirected Guidance for CT and MRI Services	10% of Imaging Services Fees	A minimum of 90% of Identified Members will receive an attempted outreach telephone call which will provide Member Redirected Guidance within 3 business days of a prior authorization approval for a CT or MRI service. This Guarantee only applies to CT and MRI services. This Guarantee will be calculated based on the total number of Identified Members who receive an attempted outreach telephone call which provides Member Redirected Guidance divided by the total number of Identified Members receiving a prior authorization approval for a CT or MRI service. This will be measured with Employer-specific Data.	100% of Amount at Risk	**Measurement Period** Annual* *This Guarantee applies to CT and MRI services that receive prior authorization approval during the Measurement Period. **Reporting Period** Annual
Member Redirection for CT and MRI Services:	10% of Imaging Services Fees	A minimum of 10% of Identified Members will receive a Member Redirected Service. This Guarantee only applies to CT and MRI services. This Guarantee will be calculated based on the total number of Identified Members who receive CT and MRI Member Redirected Guidance divided by the total number of Identified Members receiving a prior authorization approval for a CT or MRI Service. This will be measured with Employer-specific Data	100% of Amount at Risk	**Measurement Period** Annual.* *This Guarantee applies to CT and MRI services that receive prior authorization approval during the Measurement Period. **Reporting Period** Annual

ATTACHMENT TO SCHEDULE C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
OWENS & MINOR MEDICAL, INC.

EAP Performance Guarantee

This Attachment is made part of Schedule C and will be effective for the Performance Period from June 1, 2017 through December 31, 2018. This Attachment is intended to supplement and amend the Agreement between the Parties.

Additional Terms and Conditions:

- Unless otherwise provided in the description of a Performance Guarantee in this attachment, the Performance Guarantees herein require 30 or more of Employer's Members being measured in order for Anthem to have an obligation to make a payment under such Performance Guarantee
- All Performance Guarantees in which Anthem will make outbound calls to Identified Members will exclude Identified Members whom Anthem cannot reach due to incorrect or invalid telephone numbers, including numbers where permission is required by law but not provided, or those Identified Members who have requested that Anthem not contact them.
- Anthem reserves the right to revise Performance Guarantees to reflect modifications and advances in medical standards and practices when such standards and practices become generally accepted.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
EAP Average Speed to Answer	5% of EAP Fees	The average speed to answer (ASA) will be 30 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR).This Guarantee will be calculated based on the total number of calls answered by a CSR.	Result	Penalty	**Measurement Period** Annual **Reporting Period** Annual
			30 seconds or less	None	
			31-33 seconds	25%	
			34-36 seconds	50%	
			37-39 seconds	75%	
			Greater than 40 seconds	100%	
EAP Call Abandonment Rate	5% of EAP Fees	A maximum of 3% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system.	Result	Penalty	**Measurement Period** Annual **Reporting Period** Annual
			3% or Less	None	
			3.01% - 3.4%	25%	
			3.41% - 3.7%	50%	
			3.71% - 3.99%	75%	
			Greater than 4%	100%	
EAP Management Reports	5% of EAP Fees	Standard EAP reports will be made available to Employer by no later than 15 business days following the end of the month. The reports will include utilization information. This will be measured with Employer-specific Data.	Result	Penalty	**Measurement Period** Quarterly **Reporting Period** Quarterly
			By day 15	None	
			Over 15 days – once	25%	
			Over 15 days -2 times	50%	
			Over 15 days -3 times	75%	
			Over 15 days -4 times	100%	

<table>
<tr><th>Performance Category</th><th>Amount at Risk</th><th>Guarantee</th><th>Penalty Calculation</th><th>Measurement and Reporting Period</th></tr>
<tr><td>EAP Network Access</td><td>5% of EAP Fees</td><td>A minimum of 90% of Members will have Member access. Member Access is defined as access to at least 1 Network Provider in the following geographic areas:

Urban: 10 miles
Suburban: 20 miles
Rural: 45 miles

Member Access will be established by running a GeoAccess Report based on criteria established by Anthem prior to the beginning of each Measurement Period.
This Guarantee will be calculated based on the results of a GeoAccess report run at the beginning of a Measurement Period based on criteria established by Anthem compared to the results of a GeoAccess Report run at the end of a Measurement Period using the same criteria. This Guarantee will not include vision, dental or pharmacy Providers.
This will be measured with Employer-specific Data.</td><td><table><tr><th>Result</th><th>Penalty</th></tr><tr><td>90% or Greater</td><td>None</td></tr><tr><td>87.5% - 89.9%</td><td>25%</td></tr><tr><td>85% - 87.4%</td><td>50%</td></tr><tr><td>82.5% - 84.9%</td><td>75%</td></tr><tr><td>Less than 82.5%</td><td>100%</td></tr></table></td><td><u>Measurement Period</u>
Annual

<u>Reporting Period</u>
Annual</td></tr>
</table>

ATTACHMENT TO SCHEDULE C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
OWENS & MINOR MEDICAL, INC.

Pharmacy Performance Guarantees

This Attachment is made part of Schedule C and will be effective for the Performance Period from June 1, 2017 through December 31, 2018. This Attachment is intended to supplement and amend the Agreement between the **Parties**. These Performance Guarantees are guaranteed upon offer and acceptance of renewal of the medical portion of the Agreement.

Additional Terms and Conditions:

- Employer must implement Exclusive Specialty across all benefits, otherwise Retail dispensing fees will increase by $0.10 per claim.

Prescription Drug Rebate Guarantees
Minimum Drug Rebates:

(a) The Drug Rebates Employer receives from Anthem will not be less than the following amounts ("Total Drug Rebates Guarantee"):

NON-SPECIALTY BRAND NAME PRESCRIPTION DRUGS
(1) An amount equal to the sum of $64.91 (Yr1) $78.12 (Yr2) $97.19 (Yr3) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at retail pharmacy Network Providers; plus

(2) An amount equal to the sum of $228.82 (Yr1) $275.25 (Yr2) $333.29 (Yr3) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at home delivery Network Providers

SPECIALTY BRAND NAME PRESCRIPTION DRUGS
(1) An amount equal to the sum of $553.03 (Yr1) $660.29 (Yr2) $857.46 (Yr3) per Paid Claim for Specialty Brand Name Prescription Drugs dispensed at retail pharmacy Network Providers; plus

(2) An amount equal to the sum of $517.43 (Yr1) $627.42 (Yr2) $758.75 (Yr3) per Paid Claim for Specialty Brand Name Prescription Drugs dispensed at home delivery Network Providers

This Guarantee will be determined by comparing the Total Drug Rebates Guarantee to the Drug Rebates credited to the Employer pursuant to Article 14 of the Agreement and Section 3(A) of Schedule A. If the Total Drug Rebates Guarantee exceeds the Drug Rebates credited to the Employer, Anthem will credit Employer the difference.

Any payment due to Employer under a Rebate Guarantee will not be offset by favorable results achieved in any other Rebate Guarantee. Any payment due to Employer under this Guarantee will not be offset by favorable results achieved in the Prescription Drug Pricing Guarantee, nor will it be offset by favorable results achieved in the Generic Dispensing Rate Guarantee.

This will be measured with Employer-specific data.

(b) In addition to the provisions contained in Section 1(F) of Schedule C, Anthem reserves the right to make changes to this Guarantee upon the occurrence, in Anthem's determination, of any of the following:

- a failure by Employer to implement its responsibilities under the clinical management programs that are part of the Plan or a failure by Employer to participate throughout the Measurement Period in any clinical management programs listed in Schedule B of this Agreement;
- a failure by Employer to adopt the Formulary;
- a change in the proportionate mix of Employer's retail and home delivery Prescription Drug Claims of more than 10%;
- a change in pharmacy utilization patterns of more than 10%;
- a change that results in Anthem no longer being the exclusive source of Drug Rebates for Employer's Plan; or
- the determination that Employer has an on-site pharmacy with 340b designation or any such designation where the pharmacy receives upfront pricing discounts from pharmaceutical manufacturers, which was not disclosed or known by Anthem as of the effective date of this Attachment to Schedule C.
- Anthem is no longer the sole administrator for Employer's Prescription Drug Plan

(c) For purposes of these Guarantees, the following Claims will not be included in the calculation:

- Medicare Part D Claims;
- 340b pharmacy;
- Prescriptions filled through the Employer's on-site pharmacy;
- Over-the-counter drugs;
- Dispense As Written Claims with code 3;
- Dispense As Written Claims with code 4;
- Dispense As Written Claims with code 5;
- Dispense As Written Claims with code 6;
- Dispense As Written Claims with code 9;

(d) For purposes of these Guarantees, the following terms have the following meanings:

- Brand Name Prescription Drug or Brand Drug is a Prescription Drug product that is not a Generic Drug.
- Generic Prescription Drug or Generic Drug is a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.
- Formulary is a list of preferred Prescription Drugs and medical supplies developed, published, and periodically revised by Anthem.
- Specialty Drugs are drugs dispensed from a Specialty Service Pharmacy and/or high-cost, injected, infused, oral, or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty Drugs may have special handling, storage, and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance.
- Dispense As Written Claims With Code 3 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacist selected the Brand Drug.
- Dispense As Written Claims With Code 4 are Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug was not in stock.
- Dispense As Written Claims With Code 5 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacy dispensed the Brand Drug at the Generic Drug cost (also known as House Generic Claims.)
- Dispensed As Written Claims With Code 6 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of an override.
- Dispense As Written Claims With Code 9 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of other non-specified reason.

Prescription Drug Pricing Guarantees
Prescription Drug Pricing:
(a) The Prescription Drug Pricing Guarantees for Ingredient Cost Discount and Dispensing Fees will be the amounts listed under the following Pricing Guarantee Categories:

RETAIL PHARMACY NETWORK PROVIDERS
The Guarantees for retail pharmacy Network Providers will be the following amounts:

1. Brand Discount: AWP minus 17.40% (Yr1) 17.40% (Yr2) 17.40% (Yr3)
2. Brand Dispensing Fee: $0.70 (Yr1) $0.70 (Yr2) $0.70 (Yr3)
3. Generic Discount: AWP minus 79.20% (Yr1) 79.45% (Yr2) 79.70% (Yr3)
4. Generic Dispensing Fee: $0.70 (Yr1) $0.70 (Yr2) $0.70 (Yr3)
5. Overall Specialty Drugs Discount: AWP minus 16.95% (Yr1) 16.95% (Yr2) 16.95% (Yr3)
6. Overall Specialty Drugs Dispensing Fee: $2.00 (Yr1) $2.00 (Yr2) $2.00 (Yr3)

RETAIL 90 PHARMACY NETWORK PROVIDERS
The Guarantees for retail pharmacy Retail 90 Network Providers dispensing 84-90 day supplies will be the following amounts:

1. Brand Discount: AWP minus 19.50% (Yr1) 19.50% (Yr2) 19.50% (Yr3)
2. Brand Dispensing Fee: $0.35 (Yr1) $0.35 (Yr2) $0.35 (Yr3)
3. Generic Discount: AWP minus 79.20% (Yr1) 79.45% (Yr2) 79.70% (Yr3)
4. Generic Dispensing Fee: $0.35 (Yr1) $0.35 (Yr2) $0.35 (Yr3)

HOME DELIVERY PHARMACY
The Guarantees for home delivery will be the following amounts:

1. Brand Discount: AWP minus 24.25% (Yr1) 24.25% (Yr2) 24.25% (Yr3)
2. Brand Dispensing Fee: $0.00 (Yr1) $0.00 (Yr2) $0.00 (Yr3)
3. Generic Discount: AWP minus 83.30% (Yr1) 83.55% (Yr2) 83.80% (Yr3)
4. Generic Dispensing Fee: $0.00 (Yr1) $0.00 (Yr2) $0.00 (Yr3)
5. Overall Specialty Drugs Discount: AWP minus 16.95% (Yr1) 16.95% (Yr2) 16.95% (Yr3)
6. Overall Specialty Drugs Dispensing Fee: $0.00 (Yr1) $0.00 (Yr2) $0.00 (Yr3)

To determine any payment due to Employer under these Prescription Drug Pricing Guarantees, each Guarantee is calculated based on the Prescription Drugs that were paid during the Measurement Period for Retail Pharmacy, Home Delivery, and Retail 90 Pharmacy (each such subset of Paid Claims is referred to as a "Pricing Guarantee Category"). Each Guarantee within a Pricing Guarantee Category is then compared to the sum of appropriate portion of the Paid Claims for Prescription Drugs plus any Member cost shares associated with each Guarantee within that Pricing Guarantee Category. Paid Claims for Prescription Drugs include Ingredient Costs plus Dispensing Fees. Therefore, Paid Claims for Prescription Drugs dispensed by a retail pharmacy are separated into Brand and Generic Ingredient Costs and Brand and Generic Dispensing Fees. These Ingredient Costs and Dispensing Fees are compared against each identified Guarantee provided in this Agreement to determine if the Guarantee is met.
Any payment due to Employer under any Guarantee within a Pricing Guarantee Category will not be offset by: (i) favorable results achieved in any other Guarantee within that same Pricing Guarantee Category, (ii) overall favorable results for a Pricing Guarantee Category; or (iii) any Rebate Guarantee or Generic Dispensing Rate Guarantee.
This will be measured with Employer-specific data.

(b) The following conditions apply to this Guarantee:

- This Guarantee applies to Claims submitted by Network Providers applicable to Employer's Plan.
- The following Claims will be excluded from this Guarantee:
  - Medicare Part D Claims
  - Vaccines;
  - Prescriptions filled through the Employer's on-site pharmacy;
  - Claims paid on the basis of U&C charges;
  - Compound Drugs;
  - Over-the-counter drugs;

- This Guarantee applies only as long as there are at least 78,000 Annualized Adjusted Prescription Drug Claims.
- Drugs identified at the time the prescription is filled as Single Source Generics, will be included in the Generic Discount and Generic Dispensing Fee Guarantees.

• Drugs identified at the time the prescription is filled as Dispensed As Written Claims with code 3, 4, 5, 6, 9 will be included in the Generic Discount and Generic Dispensing Fee Guarantees.

(c) In addition to the provisions contained in Section 1(F) of Schedule C, Anthem reserves the right to make changes to this Guarantee upon the occurrence, in Anthem's determination, of any of the following:

• a change in the proportionate mix of Employer's retail and home delivery Prescription Drug Claims of more than 10%;
• a change in pharmacy utilization patterns of more than 10%; or
• the determination that Employer has an on-site pharmacy with 340b designation or any such designation where the pharmacy receives upfront pricing discounts from pharmaceutical manufacturers, which was not disclosed or known by Anthem as of the effective date of this Attachment to Schedule C.
• Anthem is no longer the sole administrator for Employer's Prescription Drug Plan

In the event that there are court or government imposed or industry wide or pricing source initiated changes in the AWP reporting source or source changes in the methodology used for calculating AWP, including, without limitation, changes in the mark-up factor used in calculating AWP (collectively, the "AWP Changes"), the terms of any financial relationship between the Parties that relate to AWP will be modified by Anthem such that the value of AWP for the purpose of such relationship(s) will have the same economic equivalence in the aggregate to the value used by the Parties prior to the AWP Change. The intent of this provision is to preserve the relative economics of both Parties for such financial relationships based upon AWP to that which existed immediately prior to the AWP Change.

In the event that the AWP pricing benchmark used by Anthem's PBM hereunder is replaced with another benchmark calculation, Anthem may switch to such new pricing benchmark. If a change to pricing guarantees is deemed necessary Anthem will provide written notice of new pricing terms at least 30 days before the effective date of the change.

(d) For purposes of these Guarantees, the following terms have the following meanings:

- Average Wholesale Price or AWP is the price of a prescription drug dispensed as established and reported by MediSpan or other nationally recognized pricing source selected by PBM in its sole discretion from time to time. AWP does not represent a true wholesale price, but rather is a fluctuating benchmark provided by third party pricing sources.
- Brand Name Prescription Drug or Brand Drug is a Prescription Drug product that is not a Generic Drug.
- Compound Drug is a mixture of two or more ingredients when at least one of the ingredients in the preparation is an FDA-approved Prescription Drug, excluding the addition of only water or flavoring to any preparation.
- Dispensing Fee is the amount paid by Employer to Anthem for professional services rendered by a licensed pharmacist in dispensing Prescription Drugs.
- Dispense As Written Claims With Code 3 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacist selected the Brand Drug.
- Dispense As Written Claims With Code 4 are Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug was not in stock.
- Dispense As Written Claims With Code 5 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacy dispensed the Brand Drug at the Generic Drug cost (also known as House Generic Claims).
- Dispensed As Written Claims With Code 6 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of an override.
- Dispense As Written Claims With Code 9 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of other non-specified reason.
- Generic Prescription Drug or Generic Drug is a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.
- Ingredient Cost is the ingredient cost portion of a Paid Claim for Prescription Drugs.

- Most Favored Nations Limitations are government restrictions that preclude pharmacies from making pricing agreements with PBMs or others that are more favorable than those afforded to state-run programs, such as Medicaid.
- Single Source Generics are those Generic Drugs which are provided by two or fewer Pharmaceutical Manufacturers or such Generic Drugs that are in the market with supply limitations or competitive restrictions.
- Specialty Drugs are drugs dispensed from a Specialty Service Pharmacy or high-cost, injected, infused, oral, or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty Drugs may have special handling, storage, and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance.
- Specialty Service Pharmacy is the PBM-owned or contracted specialty pharmacy that primarily dispenses Specialty Drugs, outside of the retail pharmacy Network and home delivery pharmacy.
- Usual and Customary (U&C) Charge is the amount a cash paying customer pays a pharmacy for a Prescription Drug. PBM shall require network pharmacies to submit the Usual and Customary Charges with all Claim submissions.
- Annualized Adjusted Prescription Drug Claims is the annualized sum of the total number of: (i) retail Prescription Drug Claims; (ii) home delivery Prescription Drug Claims multiplied by a factor of 3; and (iii) Specialty Prescription Drug Claims.

Generic Dispensing Rate Guarantee
(a) The Generic Dispensing Rate Employer receives from Anthem will not be less than the following amounts:

GENERIC PRESCRIPTION DRUGS RETAIL AND HOME DELIVERY PHARMACY

A minimum of 87.50% (Yr1) 88.00% (Yr2) 88.50% (Yr3) of retail drugs and a minimum of 78.00% (Yr1) 78.75% (Yr2) 79.50% (Yr3) of home delivery drugs will be dispensed as Generic Drugs.

Generic Dispensing Rate is defined as the total number of Generic Prescription Drug Claims received by Anthem divided by the total number of Prescription Drug Claims received by Anthem.

Any penalty owed for this Guarantee will be calculated as follows: Anthem shall determine the total Ingredient Cost for Generic Prescription Drugs and Brand Name Prescription Drugs by adding the Ingredient Cost for Brand Name Prescription Drugs and the Ingredient Cost for Generic Prescription Drugs. Anthem shall determine the total number of Claims received by Anthem for Brand Name Prescription Drugs and Generic Prescription Drugs. Anthem shall determine the average cost per Generic Prescription Drug by dividing the total Ingredient Cost for Generic Prescription Drugs by the total number of Generic Prescription Drug Claims received by Anthem. Anthem shall determine the average cost per Brand Name Prescription Drug by dividing the total brand Ingredient Cost by the total number of Brand Name Prescription Drug Claims received by Anthem.
Anthem shall then recalculate the total Ingredient Cost for Brand Name Prescription Drugs and Generic Prescription Drugs by multiplying the target guarantee percentages separately by the total number of Brand Name Prescription Drugs and Generic Prescription Drug claims received by Anthem which is then multiplied separately by the average Ingredient Cost per Brand Name Prescription Drug and the average Ingredient Cost per Generic Prescription Drug. The resulting difference in Ingredient Cost and the recalculated total Ingredient Cost is the penalty up to an annual maximum payout of $200,000.00.

Any payment due to Employer under this Guarantee will not be offset by any favorable results achieved in the Prescription Drug Pricing Guarantee, nor will it be offset by favorable results achieved in the Minimum Drug Rebates Guarantee. Any payment due to Employer under these Generic Dispensing Rate Guarantees will not be offset by favorable results achieved in any other Generic Dispensing Rate Guarantees.

This will be measured with Employer-specific data.

(b) The following conditions apply to this Guarantee:
- Employer must have a 3-tier benefit structure for Prescription Drugs, and a minimum $25 copay differential between Generic Prescription Drugs and Preferred Brand Name Prescription Drugs, and a $15 copay differential between Preferred Brand Name Prescription Drugs and Non-Preferred Brand Name Prescription Drugs.
- Employer must implement generic management clinical programs as recommended by Anthem.
- Employer cannot make any benefit changes that result in disadvantaging the use of Generic Prescription Drugs.
- Client must include Member pay difference logic for Brand Name Prescription Drugs that offer an AB rated equivalent Generic Prescription Drug.

(c) In addition to the provisions contained in Section 1(F) of Schedule C, Anthem reserves the right to make changes to this Guarantee upon the occurrence, in Anthem's determination, of any of the following:

- a change in the proportionate mix of Employer's retail and home delivery Prescription Drug Claims of more than 10%;
- a change in pharmacy utilization patterns of more than 10%; or
- the determination that Employer has an on-site pharmacy with 340b designation or any such designation where the pharmacy receives upfront pricing discounts from pharmaceutical manufacturers, which was not disclosed or known by Anthem as of the effective date of this Attachment to Schedule C.
- Anthem is no longer the sole administrator for Employer's Prescription Drug Plan

(d) For purposes of these Guarantees, the following terms have the following meanings:

- Brand Name Prescription Drug or Brand Drug is a Prescription Drug product that is not a Generic Drug.
- Formulary is a list of preferred Prescription Drugs and medical supplies developed, published, and periodically revised by Anthem.
- Generic Prescription Drug or Generic Drug is a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.
- Ingredient Cost is the ingredient cost portion of a Paid Claim for Prescription Drugs.
- Non-Preferred Brand Name Prescription Drug is a Brand Name Prescription drug that is not included in the Formulary.
- Preferred Brand Prescription Drug is a Brand Name Prescription Drug that is included in the Formulary.

Pharmacy Access	2% of Rx Administration Fee	Anthem will meet all of the following minimum criteria: (1) 98% of Members in urban areas will have 1 pharmacy Network Provider within 3 miles of their residence; (2) 98% of Members in suburban areas will have 1 pharmacy Network Provider within 5 miles of their residence; and, (3) 96% of Members in rural areas will have a pharmacy Network Provider within 10 miles of their residence. The obligation contained in this Guarantee is contingent upon a pharmacy existing within the GeoAccess Report standard. This Guarantee will be calculated based on the results of a GeoAccess report. Anthem has the right in its sole discretion to modify or terminate this Guarantee if Employer adopts a limited network of pharmacies. This will be measured with Employer-specific Data.	100% of Amount at Risk	
Point-of-Sale Adjudication System Availability	1% of Rx Administration Fee	The point-of-sale adjudication system will be available a minimum of 99.8% of the time, excluding any scheduled system down time.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly
Point-of-Sale Adjudication System Response Time	1% of Rx Administration Fee	The average response time for the point-of-sale adjudication system will be within 2 seconds, excluding any scheduled system down time.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly
Retail Electronic Claims Processing Accuracy	1% of Rx Administration Fee	99% of retail Claims will be processed without payment errors. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly
Home Delivery Dispensing Accuracy	1% of Rx Administration Fee	A minimum of 99.98% of home delivery Prescription Drug Claims will be dispensed without form, drug, dose or patient errors. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly

Home Delivery Pharmacy Claim Timeliness – Claims Not Requiring Intervention	1% of Rx Administration Fee	A minimum of 99% of Home Delivery Pharmacy Claims Not Requiring Intervention (Investigation) will be processed within an average of 2 business days of receipt of a valid prescription. Home Delivery Pharmacy Claims Not Requiring Intervention are defined as Home Delivery Pharmacy Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources to process the Home Delivery Pharmacy Claim. This Guarantee will be calculated based on the number of [Employer's] Home Delivery Pharmacy Claims Not Requiring Intervention processed within 2 business days divided by the total number of [Employer's] Home Delivery Pharmacy Claims Not Requiring Intervention. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies. This will be measured with Employer-specific Data.	100% of Amount at Risk	
Home Delivery Pharmacy Claim Timeliness – Claims Requiring Intervention	1% of Rx Administration Fee	A minimum of 98% of Home Delivery Pharmacy Claims Requiring Intervention (Investigation) will be processed within an average of 5 business days of receipt of a valid prescription. Home Delivery Pharmacy Claims Requiring Intervention are defined as Home Delivery Pharmacy Claims that need additional information from the Provider, Subscriber or other external sources to process the Home Delivery Pharmacy Claim. This Guarantee will be calculated based on the number of [Employer's] Home Delivery Pharmacy Claims Requiring Intervention processed within 5 business days divided by the total number of [Employer's] Home Delivery Pharmacy Claims Requiring Intervention. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies. This will be measured with Employer-specific Data.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly
Home Delivery Claims Processing Accuracy	1% of Rx Administration Fee	99% of Home Delivery Claims will be processed without payment errors. This Guarantee will be calculated based on the number of Home Delivery Pharmacy Claims paid correctly divided by the total number of Home Delivery Pharmacy Claims paid. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly

Home Delivery Customer Service – Call Abandonment Rate	1% of Rx Administration Fee	The call abandonment rate for Home Delivery Customer Service will be 3% or less of all member calls during normal business hours. Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies. This will be measured with Employer-specific Data.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly
Home Delivery Customer Service – Average Speed of Answer (ASA	1% of Rx Administration Fee	97% of all Home Delivery Customer Service calls will be answered within an average speed to answer (ASA) of 30 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR) or an interactive voice response (IVR) unit. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies. This will be measured with Employer-specific Data.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly
Retail Paper Claims Turnaround Time – Claims Not Requiring Intervention	1% of Rx Administration Fee	Retail Paper Claims Not Requiring Intervention will be processed within an average of 5 business days. Claims Not Requiring Intervention (Investigation) are defined as Pharmacy Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.	100% of Amount at Risk	
Retail Paper Claims Turnaround Time – Claims Requiring Intervention	1% of Rx Administration Fee	Retail Paper Claims Requiring Intervention will be processed within an average of 10 business days. Claims Requiring Intervention (Investigation) are defined as Pharmacy Claims that process through the system with the need to obtain additional information from the Provider, Subscriber or other external sources. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly
Retail Paper Claims Accuracy	1% of Rx Administration Fee	99% of Retail Paper Claims will be processed without payment errors. This Guarantee will be calculated based on the number of Retail Paper Pharmacy Claims paid or denied correctly divided by the total number of Retail Paper Pharmacy Claims paid. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly
On-Site Pharmacy Audits	1% of Rx Administration Fee	A minimum of 3% of retail network pharmacies filling more than 250 Claims during the previous calendar year will receive an on-site audit subject to PBM auditing standards.	100% of Amount at Risk	**Measurement Period** Annual **Reporting Period** Quarterly

INTER-PLAN ARRANGEMENTS SCHEDULE
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
OWENS & MINOR MEDICAL, INC.

This Inter-Plan Arrangement Schedule supplements and amends the Administrative Services Agreement and is effective as of June 1, 2017. In the event of an inconsistency between the applicable provisions of this Schedule, any other Schedule and/or the Agreement, the terms of this Schedule shall govern, but only as they relate to the Inter-Plan Arrangements. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements operate under rules and procedures issued by BCBSA. Whenever Members access healthcare services outside the geographic area Anthem serves (the "Anthem Service Area"), the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the Anthem Service Area, Members obtain care from healthcare Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. Anthem remains responsible for fulfilling its contractual obligations to Employer. Anthem's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that dental care, Prescription Drug or vision benefits may not be processed through Inter-Plan Arrangements.

If the Plan covers only limited healthcare services received outside of Anthem's Service Area, services other than those listed as Covered Services (e.g., emergency services) in the Benefits Booklet will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem. Providers providing such non-Covered Services will be considered Non-Participating Providers.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the Anthem Service Area, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim

a. Member Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Member liability on Claims for Covered Services will be based on the lower of the Participating Provider's Billed Charges or the negotiated price made available to Anthem by the Host Blue.

b. Employer Liability Calculation

The calculation of Employer liability on Claims for Covered Services will be based on the negotiated price made available to Anthem by the Host Blue. Sometimes, this negotiated price may be greater for a given service or services than the Billed Charges in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the Billed Charges, Employer may be liable for the excess amount even when

the Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Participating Provider, even when the contracted price is greater than the Billed Charges.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Participating Provider contracts. The negotiated price made available to Anthem by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of Billed Charges in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Participating Providers or a similar classification of its Participating Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific Claim and the actual amount the Host Blue pays to the Participating Provider. However, the BlueCard Program requires that the amount paid be a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. Upon termination, Employer will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

B. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Anthem may process Claims for Covered Services through negotiated arrangements. A negotiated arrangement is an agreement negotiated between Anthem and one or more Host Blues for any Employer that is not delivered through the BlueCard Program ("Negotiated Arrangement").

In addition, if Anthem and Employer agree that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in Anthem's Negotiated Arrangement(s) with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Members access such network(s). In negotiating such arrangement(s), Anthem is not acting on behalf of or as an agent for Employer, the Plan or Members.

Member Liability Calculation

The calculation of Member cost-sharing will be based on the lower of either Billed Charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to Anthem and that allows Members access to Participating Providers.

C. Special Cases: Value-Based Programs

Definitions

1. **Accountable Care Organization (ACO):** A group of Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.
2. **Care Coordination:** Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
3. **Care Coordinator:** An individual within a Provider organization who facilitates Care Coordination for patients.
4. **Care Coordinator Fee:** A fixed amount paid by a Host Plan to Providers periodically for Care Coordination under a Value-Based Program.
5. **Global Payment/Total Cost of Care:** A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient, such as outpatient, physician, ancillary, hospital services, and prescription drugs.
6. **Patient-Centered Medical Home (PCMH):** A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.
7. **Provider Incentive:** An additional amount of compensation paid to a Provider by a Host Blue, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.
8. **Shared Savings:** A payment mechanism in which the Provider and the payer share cost savings achieved against a target cost budget based on agreed upon terms and may include downside risk.
9. **Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Value-Based Programs Overview

Members may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to Anthem, which Anthem will pass directly on to Employer as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Employer via an enhanced Provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the Claim, they may be billed using a Per Member Per Month billing for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Anthem will pass these Host Blue charges directly through to Employer as a separately identified amount on the Employer billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.

- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If the Agreement terminates, Employer will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Members will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

Host Blues may also bill Anthem for Care Coordinator Fees for Provider services which Anthem will pass on to Employer as follows:

1. PMPM billings; or

2. Individual Claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare

Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

Anthem and Employer will not impose Member cost-sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted above.

D. Non-Participating Providers Outside Anthem's Service Area

1. Allowed Amounts and Member Liability Calculation

Unless otherwise described in the Benefits Booklet, when Covered Services are provided outside of Anthem's Service Area by Non-Participating Providers, Anthem may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount the Member pays for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment Anthem will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, which may occur at Employer's direction, Anthem may use other pricing methods, such as Billed Charges, the pricing Anthem would use if the healthcare services had been obtained within Anthem's Service Area, or a special negotiated price to determine the amount Anthem will pay for services provided by Non-Participating Providers. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Anthem makes for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core Program

General Information

If Members are outside the United States (hereinafter, "BlueCard Service Area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard Service Area, Members will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Member paid in full at the time of service, the Member must submit a Claim to obtain reimbursement for Covered Services.

Outpatient Services

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard Service Area will typically require Members to pay in full at the time of service. Members must submit a Claim to obtain reimbursement for Covered Services.

F. Return of Overpayments

Recoveries of overpayments can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, utilization review refunds and unsolicited refunds. Recoveries will be applied, in general, on either a Claim-by-Claim or prospective basis. If recovery amounts are passed on a Claim-by-Claim basis from a Host Blue to Anthem they will be credited to Employer. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to Employer as a percentage of the recovery.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Anthem will request the Host Blue to provide full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Anthem will request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this Agreement.

G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees or compensation are generally made effective January 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes resulting in an increase in fees paid by Employer, Anthem shall provide Employer with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangements fees or compensation describing the change and the effective date thereof and Employer right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Anthem will then allow such modifications to become part of this Agreement.

H. Fees and Compensation

Employer agrees to reimburse Anthem for certain fees and compensation which Anthem is obligated under the applicable Inter-Plan Arrangements described in this Schedule to pay to the Host Blues, to BCBSA and/or to vendors of BlueCard Program-related services. The specific Inter-Plan Arrangements fees and compensation, including any administrative and/or network access fee that a Host Blue may charge under the BlueCard Program, a Negotiated Arrangement, and BlueCard Worldwide are charged to Employer are set forth in Section 7 of Schedule A to the Agreement. The various Inter-Plan Arrangements Fees and compensation may be revised from time to time as described in section G.

A description of the various Claim processing fees that may be listed on Schedule A is as follows:

Access Fee: The Access Fee is charged by the Host Blue to Anthem for making its applicable Provider network available to Members. The Access Fee will not apply to Non-Participating Provider Claims. The Access Fee is charged on a per Claim basis and is charged as a percentage of the discount/differential Anthem receives from the applicable Host Blue subject to a maximum of $2,000 per Claim.

Instances may occur in which the Claim payment is zero or Anthem pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Anthem will pay the Host Blue's Access Fee and pass it along directly to Employer as stated above even though Employer paid little or had no Claim liability.

Administrative Expense Allowance (AEA) Fee: The AEA Fee is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. The dollar amount is normally based on the type of Claim (e.g. institutional, professional, international, etc.) and can also be based on the size of group enrollment. When charged, Anthem passes the AEA Fee directly on to Employer.

Per Subscriber Per Month (PSPM) Fee: The PSPM Fee is a financial arrangement negotiated between the Host Blue and Employer and replaces all other fees, including the Access Fee and AEA. The PSPM dollar amount is

charged on a per Subscriber per month basis by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. The dollar amount can also be based on the size of group enrollment.

Non-Standard AEA Fee: The Non-Standard AEA Fee is a financial arrangement negotiated between the Host Blue and Anthem and replaces all other fees, including the Access Fee and AEA. The Non-Standard AEA is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members.

Central Financial Agency (CFA) Fee: The CFA connects Blue Cross and/or Blue Shield Licensee's local bank accounts to an automated clearinghouse (ACH). The CFA Fee is a fixed dollar amount per payment notice and is paid by Anthem to BCBSA outside of the CFA. This fee applies each time Anthem receives an electronic payment notice from the CFA indicating that a Host Blue incurred Claim-related liability on Anthem's behalf and requesting that Anthem either approve or deny payment.

ITS Transaction Fee: The ITS delivery platform allows all Blue Cross and/or Blue Shield Licensees to connect with each other through a standardized system to facilitate the operation of Inter-Plan Arrangements. The ITS Transaction Fee applies each time a Claims transaction interchange occurs between Anthem and a Host Blue. When a Host Blue receives a Claim, it applies Provider pricing information, sets forth its discount and related savings and sends this information to Anthem electronically. Anthem then adjudicates the Claim, computes the approved Provider payment amount, calculates the AEA and Access Fee, computes net liability and sends a response electronically to the Host Blue. The Host Blue then pays the Provider and issues an electronic payment notice to Anthem via the CFA. The ITS Transaction Fee is five cents per interchange and is paid to BCBSA. For each Claim, there are a minimum of three interchanges, but there could be more depending on the complexity of the Claim.

Other potential BlueCard Program-related fees include:

Toll-free (e.g., 800 number) Number Fees: These fees are charged by BCBSA to Anthem.

- BlueCard Eligibility (800.676.BLUE*)* – This service provides a centralized number for Providers to reach a Member's Home Licensee to obtain information on membership, coverage and pre-certification. The fees represent charges allocated to the member's Home Licensee based on the percentage of calls by alpha prefix.

- BlueCard Access (800.810.BLUE) – This service provides a centralized number for Members to obtain a list of Participating Providers. The fees represent charges allocated to a Member's Home Licensee based on calls by alpha prefix.

PPO Provider Directory Fee: This service provides print-on-demand Provider directories. This fee is charged by BCBSA to Anthem. Anthem passes the PPO Provider Directory Fee directly on to Employer if printed directories are requested. The amount of the fee is dependent upon page length and number ordered; includes shipping, taxes and system maintenance costs.

EXHIBIT B

MEDICAL BENEFIT BOOKLET

For

OWENS & MINOR, INC.

Core PPO Plan

Effective Date: January 1, 2020

Administered By

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

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

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

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

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

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

Important: This is not an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

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

Identity Protection Services
Identity protection services are available with Your Employer's Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.

MEMBER RIGHTS AND RESPONSIBILITIES

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

You have the right to:

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

You have the responsibility to:

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

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

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

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

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the Definitions and Claims Payment sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

Schedule of Benefits	Network	Out-of-Network
Plan Year Deductible		
• **Individual**	**$2,500**	**$7,500**
• **Family**	**$5,000**	**$15,000**
Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.		
All Covered Services are subject to the Deductible unless otherwise specified in this booklet.		
Amounts satisfied toward the Out-of-Network Plan year Deductible will also be applied toward the Network Plan year Deductible. Amounts satisfied toward the Network Plan year Deductible will **NOT** be applied toward the Out-of-Network Plan year Deductible.		
Your Plan has an embedded Deductible which means: • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the "Individual" and the "Family" amounts apply. The "Family" Deductible amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Deductible amount before the "Family" amount is met. You will never have to satisfy more than Your own "Individual" Deductible amount. If You meet Your "Individual" Deductible amount, Your other family member's claims will still accumulate towards their own "Individual" Deductible and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Deductible or the entire "Family" Deductible is met.		
Coinsurance After the Plan Year Deductible is Met (Unless Otherwise Specified)		
• **Plan Pays**	**70%**	**50%**
• **Member Pays**	**30%**	**50%**
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		

Schedule of Benefits	Network	Out-of-Network
Out-of-Pocket Maximum Per Plan Year Includes Coinsurance, Plan Year Deductible and Copayments.		
• **Individual**	**$6,550**	**$19,650**
• **Family**	**$13,100**	**$39,300**
Does NOT include charges in excess of the Maximum Allowed Amount, Non-Covered Services, services deemed not Medically Necessary by Medical Management and/or Anthem and penalties for non-compliance.		
Amounts satisfied toward the Out-of-Network Out-of-Pocket Maximum will also be applied toward the Network Out-of-Pocket Maximum. Amounts satisfied toward the Network Out-of-Pocket Maximum will **NOT** be applied toward the Out-of-Network Out-of-Pocket Maximum.		
Your Plan has an embedded Out-of-Pocket which means: • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the "Individual" and "Family" amounts apply. The "Family" Out-of-Pocket amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Out-of-Pocket amount before the "Family" amount is met. You will never have to satisfy more than Your own "Individual" Out-of-Pocket amount. If You meet Your "Individual" amount, other family member's claims will still accumulate towards their own "Individual" Out-of-Pocket and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Out-of-Pocket or the entire "Family" Out-of-Pocket is met.		

Benefits	Network (You Pay)	Out-of-Network (You Pay)
Note: All dollar and visit limits are combined Network and Out-of-Network, unless otherwise noted. Any benefits with combined visit limits will count services on the same date of service as 1 visit, unless otherwise noted.		
Allergy Care		
• Allergy Treatment and Testing	No Deductible/0%	Deductible/50%
Behavioral Health / Substance Abuse Care		
Hospital Inpatient Services Accommodations/Ancillaries		
• Institutional / Residential Treatment Centers	Deductible/30%	Deductible/50%
• Professional	Deductible/30%	Deductible/50%
• Includes Detox • Includes Eating Disorders • Methadone Clinics are covered. • Applied Behavioral Analysis (ABA) Therapy is not covered.		
Outpatient Services		
• Institutional and Professional Outpatient	Deductible/30%	Deductible/50%
• Professional – Office, including Online Visits	$30 Copayment	Deductible/50%
• Includes Intensive Outpatient Therapy (IOP) and Partial Hospitalization (PHP). • Eating Disorders are covered. • Methadone Clinics are covered. • Applied Behavioral Analysis (ABA) Therapy is not covered		
Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.		
Clinical Trials Please see Clinical Trials under Benefits section for further information.	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Dental Accident / Oral Surgery / TMJ Services		
Dental Accident • Treatment of an accidental Injury to sound and natural teeth. • Treatment must be completed within 12 months of the accident.	Covered at the benefit level of the services billed	Covered at the Out-of-Network benefit level of the services billed
TMJ Treatment • Medical treatment (surgical and non-surgical) • Appliances	Not Covered	Not Covered

Benefits	Network (You Pay)	Out-of-Network (You Pay)
Dental Accident / Oral Surgery / TMJ Services continued…		
Oral Surgery • Excludes removal of impacted teeth • Dental Anesthesia is covered if related to a payable oral surgery	Covered at Surgical level	Covered at Surgical level
Diagnostic Services / Diagnostic X-ray and Lab Tests		
• Outpatient Institutional/*Professional, Independent Lab and Pre-surgical and Pre-admission Testing	No Deductible/30%	Deductible/50%
• *High Diagnostic Imaging (MRI, MRA, CAT, PET and SPECT)	Deductible/30%	Deductible/50%
• Office Setting		
○ Primary Care Physician	$30 Copayment	Deductible/50%
○ Specialty Care Physician	$60 Copayment	Deductible/50%
*Hospital based professional services by non-par providers are covered at the Network benefit level if rendered at a Network Facility. **Note: Diagnostic services are any claim for services performed to diagnose an illness or Injury.**		
Emergency Care, Urgent Care, and Ambulance Services		
Emergency Medical Condition - Emergency Room • Facility/Professional/Emergency Room Physician (See Note)	Deductible/30%	Deductible/30%
Non-Emergency Medical Condition - Emergency Room • Facility / Professional/Emergency Room Physician (See Note)	Deductible/30%	Deductible/50%
Urgent Care (See Note)		
• Outpatient Institutional	$60 Copayment	Deductible/50%
• Outpatient Professional	No Deductible/0%	Deductible/50%
• Office Professional		
○ Primary Care Physician	$30 Copayment	Deductible/50%
○ Specialty Care Physician	$60 Copayment	Deductible/50%
Ambulance (Air / Ground) – Medically Necessary	Deductible/30%	Deductible/30%
Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		

Benefits	Network (You Pay)	Out-of-Network (You Pay)
Eye Care – Medically Necessary		
• Medical eye care exams (treatment of disease or Injury to the eye) Includes Vision Therapy		
○ Outpatient	Deductible/30%	Deductible/50%
○ Office		
• Primary Care Physician	$30 Copayment	Deductible/50%
• Specialty Care Physician	$60 Copayment	Deductible/50%
• Glasses or contacts following cataract surgery Limited to one occurrence and includes initial frames and lenses, or contact lenses following cataract surgery	Deductible/30%	Deductible/50%
Vision Hardware	Not Covered	Not Covered
Hearing Care – Medically Necessary		
• Audiometric exam / Hearing evaluation test.		
○ Outpatient	Deductible/30%	Deductible/50%
○ Office		
• Primary Care Physician	$30 Copayment	Deductible/50%
• Specialty Care Physician	$60 Copayment	Deductible/50%
• Hearing aids and hearing aid accessories are not covered		
Home Health Care (HHC) Services	Deductible/30%	Deductible/50%
• Home Health Care is limited to 100 visits per benefit period combined Network and Out-of-Network		
Home Infusion Therapy is covered and visits do not count toward the HHC visit maximum.	Deductible/30%	Deductible/50%
Private Duty Nursing	Deductible/30%	Deductible/50%
• Is only covered in the home		
• Visits count toward the HHC visit maximum		
Hospice Care Services	Deductible/30%	Deductible/50%
• Respite Care is covered		
• Bereavement Counseling is covered	Covered at the benefit level of the services billed	Deductible/50%
Hospital Inpatient Services – Pre-certification Required		
• **Room and Board (Semiprivate or ICU/CCU) and Hospital Ancillary Services**	Deductible/30%	Deductible/50%
• **Inpatient Physical Medical Rehab**	Deductible/30%	Deductible/50%
○ Limited to 60 days per Plan Year, combined Network and Out-of-Network		

Benefits	Network (You Pay)	Out-of-Network (You Pay)
Inpatient Hospital Services continued…		
• **Inpatient Therapies** ○ Cardiac Rehab / Chemotherapy / Radiation / Dialysis/ Hemodialysis / Infusion / Physical / Occupational / Speech / Respiratory / Vision	Deductible/30%	Deductible/50%
• **Physician Services:** ► Surgeon ► Assistant Surgeon ► Anesthesiologist ► Radiologist / Pathologist (Diagnostic X-rays / Lab Tests)	Deductible/30%	Deductible/50%
Anesthesiologist, Radiologist / Pathologist (Diagnostic X-rays / Lab Tests) and Assistant Surgeon: Hospital based provider services rendered by non-par providers are covered at the Network benefit level if rendered at a Network Facility.		
• **Inpatient Medical Care** ► General Medical Care / Intensive Care / Monitoring Consultations / Second Opinions ► Newborn Care - Includes newborn vision/hearing screening when rendered in an inpatient setting.	Deductible/30%	Deductible/50%
Note: • For well newborn, no separate deductible is applied. The charge is applied to the mother's claim only.		
Maternity Care and Other Reproductive Services (Physician)		
Maternity Care	Deductible/30%	Deductible/50%
• First pre-natal visit applies copayment, then all other pre-natal visits apply at Deductible/Coinsurance • Global care (includes pre-and post-natal, delivery) • Dependent daughter maternity is covered. • Therapeutic and Elective abortion is covered.		
Infertility Services • Covered for services to diagnosis and treat infertility, including Artificial Insemination and Invitro Fertilization, limited to $20,000 per lifetime, combined Network and Out-of-Network, Medical and Prescription Drugs. • Treatment for underlying medical conditions are covered as medical.	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed

Benefits	Network (You Pay)	Out-of-Network (You Pay)
Maternity Care and Other Reproductive Services continued…		
Sterilization Services (Precertification required for Inpatient procedures)	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
• Sterilization (Vasectomy) is covered. • Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section in Benefits for further details. • Reversal of elective sterilization is not covered.		
Medical Supplies and Equipment		
Durable Medical Equipment (Purchase/Rental)	Deductible/30%	Deductible/50%
• Byram DME Supplier	Deductible/0%	Deductible/50%
Medical Supplies	Deductible/30%	Deductible/50%
Diabetic Supplies	Deductible/30%	Deductible/50%
• Diabetic supplies covered under a Pharmacy Plan are not covered under the Medical Plan, including lancets, syringes, insulin, etc. Diabetic supplies not covered under Pharmacy are covered by the Medical Plan.		
Prosthetics and Orthotics	Deductible/30%	Deductible/50%
• Wigs / Toupees are limited to $1,000 per benefit period, subject to Medical Necessity, combined Network and Out-of-Network. • Includes foot orthotics, based on Medical Necessity		
Nutritional Counseling/Education (Diabetic and Non-Diabetic)		
➢ Outpatient	Deductible/30%	Deductible/50%
➢ Office		
• Primary Care Physician	$30 Copayment	Deductible/50%
• Specialty Care Physician	$60 Copayment	Deductible/50%
• Limited to 3 visits per benefit period, combined Outpatient and Office and combined Network and Out-of-Network • When part of HCR services refer to Preventive Care Benefits. • Eating Disorders are covered.		

Benefits	Network (You Pay)	Out-of-Network (You Pay)
Outpatient Hospital / Facility Services / Ambulatory		
• Outpatient Hospital Services (Institutional)	Deductible/30%	Deductible/50%
• Ambulatory Surgical Center (Institutional)	Deductible/30%	Deductible/50%
• Clinic (Institutional)	Deductible/30%	Deductible/50%
• Pre-surgical / Pre-admission Testing	No Deductible/30%	Deductible/50%
• Outpatient Physician services (surgeon, assistant surgeon, anesthesiologist, radiologist, pathologist, etc.)	Deductible/30%	Deductible/50%
Anesthesiologist, Radiologist / Pathologist (Diagnostic X-rays / Lab Tests) and Assistant Surgeon: Hospital based provider services rendered by non-par providers are covered at the Network benefit level if rendered at a Network Facility.		
Obesity (Bariatric) Surgery	Not Covered	Not Covered
Physician Services/Visits (Office/Home/Outpatient)		

Visits
• Includes Consultations and Second Opinions
• Office Surgery
• Includes Family Planning
  ○ Outpatient
  ○ Office / Home
  • Primary Care Physician
  • Specialty Care Physician
	
	Deductible/30%
	
	$30 Copayment
	$60 Copayment
		
		Deductible/50%
		
		Deductible/50%
		Deductible/50%

Important Note on Office Visits at an Outpatient Facility: If you have an office visit with your Primary Care Physician or Specialty Care Physician at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under the "Outpatient Facility" section earlier in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
Online Visit • Includes Live Health Online providers only. All other online providers are not covered. (For Behavioral Health and Substance Abuse, see that section for benefit details)	$15 Copayment	Not Covered
Immunizations (Non-routine) and Injections including Administration When part of HCR refer to Preventive Care Benefit Travel Immunizations are not covered. • Outpatient • Office	 Deductible/30% No Deductible/0%	 Deductible/50% Deductible/50%

Benefits	Network (You Pay)	Out-of-Network (You Pay)
Blood Processing and Storage	Deductible/30%	Deductible/50%
ADD/ADHD • Includes Autistic Disease, Intellectual Disability, Developmental Delays and Learning Disabilities	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Preventive Services (unless otherwise stated below) • Prostate Cancer Screenings (PSA) • Pap Smear • Mammography • Colon Cancer Screenings (See Note) Note: Incudes routine fecal occult blood test, routine barium edema, routine Sigmoidoscopy/Colonoscopy. Facility and anesthesia billed for routine Sigmoidoscopy/Colonoscopy are covered at the same level as the routine Sigmoidoscopy/Colonoscopy. All services related to routine Sigmoidoscopy/Colonoscopy are covered at the same level as the routine Sigmoidoscopy/Colonoscopy.	No Deductible/0% No Deductible/0% No Deductible/0% No Deductible/0% No Deductible/0%	Not Covered Deductible/50% Deductible/50% Deductible/50% Deductible/50%
Retail Health Clinic	$30 Copayment	Deductible/50%
Skilled Nursing Facility • Limited to 60 days per Plan Year, combined Network and Out-of-Network	Deductible/30%	Deductible/50%
Therapy Services (Outpatient/Office) (Institutional and Professional)		
Biofeedback Therapy	Not Covered	Not Covered
Dialysis / Hemodialysis	Deductible/30%	Deductible/50%
Acupuncture Therapy • Outpatient (Institutional and Professional) • Office Professional Limited to 26 visits per benefit period, combined Institutional and Professional, combined Network and Out-of-Network. Limit does not combine with any other therapy limit.	Deductible/30% $60 Copayment	Deductible/50% Deductible/50%

Cardiac Rehab
• Outpatient:
  ○ Institutional
  ○ Professional
• Office Professional
Limited to 36 visits per benefit period, combined Institutional and Professional, combined Network and Out-of-Network. Limit does not combine with any other therapy limit.
	$60 Copayment
	No Deductible/0%
	$60 Copayment
		Deductible/50%
		Deductible/50%
		Deductible/50%

Chemotherapy / Infusion Therapy / Radiation Therapy • Outpatient (Institutional and Professional) • Office Professional:	Deductible/30%	Deductible/50%

Benefits	Network (You Pay)	Out-of-Network (You Pay)
○ Primary Care Physician ○ Specialty Care Physician	$30 Copayment $60 Copayment	Deductible/50% Deductible/50%
Therapy Services continued…		
Occupational Therapy / Physical Therapy / Speech Therapy / Respiratory Therapy / Cognitive Therapy • Outpatient: ○ Institutional ○ Professional • Office Professional: ○ Primary Care Physician ○ Specialty Care Physician Limited to 90 visits per Plan Year, combined Institutional and Professional, combined Network and Out-of-Network. Visit limit is combined with Occupational Therapy, Physical Therapy, Speech Therapy, Respiratory Therapy and Cognitive Therapy. However, this therapy limit does not combine with any other plan therapy limit.	 $60 Copayment No Deductible/0% $30 Copayment $60 Copayment	 Deductible/50% Deductible/50% Deductible/50% Deductible/50%
Manipulation Therapy • Primary Care Physician • Specialty Care Physician Limited to 30 visits per Plan Year, includes manipulations only regardless of provider specialty combined Network and Out-of-Network. Limit does not combine with any other therapy limit.	 $30 Copayment $60 Copayment	 Deductible/50% Deductible/50%
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		

Transplants	**(You Pay)**
Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy.	
The Center of Excellence requirements do not apply to Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.	
Note: Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.)	
Transplant Benefit Period	
Center of Excellence/Network Transplant Provider Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Member Services number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)	
Out-of-Network Transplant Provider Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.	
Live Donor Health Services	
• **BDCT Facility**	No Deductible/0%
• **Network**	Deductible/30%
• **Out-of-Network**	Deductible/50%
Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	
Bone Marrow Donor Search Limited to $30,000 per transplant, combined BDCT, Network and Out-of-Network	
• **BDCT Facility**	No Deductible/0%
• **Network**	Deductible/30%
• **Out-of-Network**	Deductible/50%
Organ Transplants Donor expenses are covered. Artificial hearts are covered.	
Institutional and Professional:	
• **BDCT Facility**	No Deductible/0%
• **Network**	Deductible/30%
• **Out-of-Network**	Deductible/50%

Transplants	(You Pay)
Travel and Lodging • **BDCT Facility** • **Network** • **Out-of-Network**	 No Deductible/0% Deductible/30% Deductible/50%
Provided the patient lives at least 75 miles from the covered transplant facility, lodging allowance is $50 per day for double occupancy and travel and lodging is limited to $10,000 per transplant, combined BDCT, Network and Out-of-Network.	

Benefits	Network	Out-of-Network
Prescription Drugs		
Prescription Drug Out-of-Pocket Limit **Retail and Mail Order**		
• Per Member	$6,550	Not Covered
• Per Family	$13,100	Not Covered
Note: The Network Out-of-Pocket amount combines with the Medical Plan's Network Out-of-Pocket Limit for Covered Services in this Plan. It includes all Copayments You pay for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy during a Benefit Period. Once the Network Out-of-Pocket Limit is satisfied, You will not have to pay any additional Copayments for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy for the rest of the Benefit Period.		
Retail Pharmacy Copayment (31-day supply)		
• Tier 1 – Copayment per Prescription	$15	Not Covered
• Tier 2 – Copayment per Prescription	$60	Not Covered
• Tier 3 – Copayment per Prescription	$75	Not Covered
• Tier 4 – Specialty Drugs	50% with $125 maximum	Not Covered
Note: A 90-day supply is available at Maintenance Pharmacies. When You get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply (excluding Retail Pharmacies). When You get a 30-day supply, one Copayment per Prescription Order will apply.		
Home Delivery (Mail Service) Prescription Drugs **Copayment (90-day supply)**		
• Tier 1 – Copayment per Prescription	$38	Not Covered
• Tier 2 – Copayment per Prescription	$125	Not Covered
• Tier 3 – Copayment per Prescription	$188	Not Covered
• Tier 4 – Specialty Drugs (30 day supply limit)	50% with $125 maximum	Not Covered
Note: The available day supply may be less than the 31 or 90 days shown above due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.		
Note: Covered Preventive Prescription Drugs including immunizations are covered in full.		

Benefits	Network	Out-of-Network
Prescription Drugs		
Note: If You request a Tier 2 or Tire 3 Drug when a Tier 1 Drug is available, You will be required to pay the difference in cost between the Tier 2 or Tire 3 Drug and the Tier 1 Drug, in addition to the Tier 1 Copayment. If, however, the prescriber writes "Dispense as Written" or "Do not Substitute," or if there is no Tier 1 Drug available, You will only have to pay the Tier 2 or Tier 3 Copayment as applicable.		
Note: A limited number of Prescription Drugs require Prior Authorization for Medical Necessity. If Prior Authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires Prior Authorization, please call Member Services. If an Out-of-Network Pharmacy is used, the Member must file a claim for reimbursement; the Member may be responsible for the difference between the negotiated rate and the Pharmacy's actual charge.		
Note: Certain asthmatic supplies are covered subject to applicable Prescription Drug Copayments when obtained from a Network Pharmacy. Diabetic supplies are covered in full when obtained from a Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if obtained from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment.		

TOTAL HEALTH AND WELLNESS SOLUTION

Quick Care Options

Quick Care Options helps to raise Your awareness about appropriate alternatives to Hospital emergency rooms (ERs). When You need care right away, Retail Health Clinics and Urgent Care centers can offer appropriate care for less cost and leave the ER available for actual emergencies. Quick Care Options educates You on the availability of ER alternatives for non-urgent diagnoses and provides the Provider finder website to support searches for ER alternatives.

ComplexCare

The ComplexCare program reaches out to You if You are at risk for frequent and high levels of medical care in order to offer support and assistance in managing Your health care needs. ComplexCare empowers You for self-care of Your condition(s), while encouraging positive health behavior changes through ongoing interventions. ComplexCare nurses will work with You and Your Physician to offer:

- Personalized attention, goal planning, health and lifestyle coaching.
- Strategies to promote self-management skills and medication adherence.
- Resources to answer health-related questions for specific treatments.
- Access to other essential health care management programs.
- Coordination of care between multiple Providers and services.

The program helps You effectively manage Your health to achieve improved health status and quality of life, as well as decreased use of acute medical services.

ConditionCare Programs

ConditionCare programs help maximize Your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult).
- Diabetes (pediatric and adult).
- Heart failure (HF).
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).

You will receive:

- 24/7 phone access to a nurse coach who can answer Your questions and give You up-to-date information about Your condition.
- A health review and follow-up calls if You need them.
- Tips on prevention and lifestyle choices to help You improve Your quality of life.

Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special

management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches supported by pharmacists, registered dietitians, social workers and medical directors. You will receive:

- 24/7 phone access to a nurse coach who can talk with You about Your pregnancy and answer Your questions.
- *Your Pregnancy Week by Week*, a book to show You what changes You can expect for You and Your baby over the next nine months.
- Useful tools to help You, Your Physician and Your Future Moms nurse coach track Your pregnancy and spot possible risks.

24/7 NurseLine

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

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

Standard [Autism Spectrum Disorders (ASD) Program

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

Education

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

Guidance

- Applied Behavior Analysis management, including clinical reviews by experienced licensed clinicians. Precertification delivers value, ensuring that the Member receives the right care, from the right Provider, at the right intensity.

- Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning, and referrals.
- Assure that parents and siblings have the best support to manage their own needs.

Coordination

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

MyHealth Advantage

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

Virtual Second Opinion

Facing a medical decision? The Virtual Second Opinion program allows You access to highly specialized Physicians who can provide educational guidance for certain diagnoses, procedures, or courses of treatment. Our advanced analytics engine helps to identify You and other Members to offer support through our nurses and will refer to an independent company that will handle Your second opinion.

With the Virtual Second Opinion program You can:

Learn more about Your condition.

Make sure Your diagnosis is correct.

Better understand and compare Your treatment options.

Find a high quality doctor.

Gain confidence in the treatment You choose.

ELIGIBILITY

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

Coverage for the Teammate

This Benefit Booklet describes the benefits a Teammate may receive under this health care Plan. The Teammate is also called a Subscriber.

Coverage for the Teammate's Dependents

If the Teammate is covered by this Plan, the Teammate may enroll his or her eligible Dependents. Covered Dependents are also called Members.

Eligible Dependents Include:

- The Teammate's Spouse. For information on spousal eligibility please contact the Employer.
- The Teammate's dependent children until the end of the month they attain age 26, legally adopted children from the date the Teammate assumes legal responsibility, foster children that live with the Teammate and for whom the Teammate is the primary source of financial support, children for whom the Teammate assumes legal guardianship and stepchildren. Also included are the Teammate's children (or children of the Teammate's Spouse) for whom the Teammate has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically impaired and totally dependent on the Teammate for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the impairment is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically. You must notify the Claims Administrator and/or the Employer if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

Initial Enrollees

Initial Enrollees and eligible Dependents who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Coverage will be effective based on the waiting period chosen by the Employer, and will not exceed 90 days.

New Hires

Applications for enrollment must be submitted within 31 days from the date a Teammate is eligible to enroll as set by the Employer. Applications for membership may be obtained from the Employer. Coverage will be effective based on the waiting period chosen by the Employer and will not exceed 90 days. If the Teammate or the Teammate's Dependents do not enroll when first eligible, the Teammate or the Teammate's Dependents will be treated as Late Enrollees. Please refer to the "Late Enrollees" provision listed below.

Late Enrollees

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

Special Enrollment Periods

If a Teammate or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Teammate or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

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

Important Notes About Special Enrollment:

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

Medicaid and CHIP Special Enrollment/Special Enrollees

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

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

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

When Coverage Begins

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

Changing Coverage

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

Types of Coverage

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

Changing Coverage (Adding a Dependent)

You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Teammate has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

Marriage and Stepchildren

A Teammate may add a Spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If a Teammate does not apply for coverage to add a Spouse and stepchildren within 31 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Newborn and Adopted Children

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

Nondiscrimination

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

OBRA 1993 and Qualified Medical Child Support Orders

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

An eligible Dependent child includes:

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

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

Family and Medical Leave

If a covered Teammate ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Teammate continued in active employment. The Teammate must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Coverage or Removing a Dependent

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

- divorce;
- death of an enrolled family Member (a different type of coverage may be necessary);
- Dependent child reaches age 26 (see **When Coverage Terminates**); or
- Enrolled Dependent child becomes totally or permanently disabled.

Teammate Not Actively at Work

Generally, if a Teammate is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Teammate returns to active status. If a Teammate is not actively at work due to health status, this provision will not apply. A Teammate is also a person still employed by the Employer but not currently active due to health status.

HOW YOUR PLAN WORKS

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

Introduction

Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

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

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

Network Services

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

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

To see a Doctor, call their office:

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

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

For services from Network Providers:

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

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

After Hours Care

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

Out-of-Network Services

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

For services from an Out-of-Network Provider:

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

How to Find a Provider in the Network

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

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

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

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard," which provides services to You when You are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the **Claims Payment** section.

Copayment

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

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

Plan Year Deductible

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

HEALTH CARE MANAGEMENT - PRECERTIFICATION

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this 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. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, 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.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Plan 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.

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

Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides 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 Service under Your Plan;
4. The service cannot be subject to an Exclusion under Your Plan; and
5. You must not have exceeded any applicable limits under Your Plan.

Types of Reviews:

- **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. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Benefit Booklet.

  For admissions following Emergency Care, You, Your authorized representative or Doctor must tell the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time. 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 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 the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Failure to Obtain Precertification Penalty:

IMPORTANT NOTE: IF YOU OR YOUR NON NETWORK PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, A $250 PENALTY WILL APPLY AND YOUR OUT-OF-POCKET COSTS WILL INCREASE. THIS DOES NOT APPLY TO MEDICALLY NECESSARY SERVICES FROM A NETWORK OR BLUECARD PROVIDER.

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

Inpatient Admissions

- Emergency Admissions (Requires Plan notification no later than 2 business days after admission)
- Inclusive of all Acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehab, and OB delivery stays beyond the Federal Mandate minimum length of stay (including newborn stays beyond the mother's stay)

Outpatient Admissions

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Ambulance Services: Air and Water (excludes 911 initiated emergency Transport)
- Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
- Bone-Anchored and Bone Conduction Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cervical Total Disc Arthroplasty
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diagnostic Testing
  - ► Gene Expression Profiling for Managing Breast Cancer Treatment
  - ► Genetic Testing for Cancer Susceptibility
- DME/Prosthetics

  - ► Augmentative and Alternative Communication (AAC) Devices/Speech Generating Devices (SGD)
  - ► Electrical Bone Growth Stimulation
  - ► External (Portable) Continuous Insulin Infusion Pump
  - ► Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
  - ► Microprocessor Controlled Lower Limb Prosthesis
  - ► Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
  - ► Pneumatic Compression Devices for Lymphedema
  - ► Prosthetics: Electronic or externally powered and select other prosthetics
  - ► Standing Frame
  - ► Wheeled Mobility Devices: Manual Wheelchairs-Ultra Lightweight
  - ► Wheeled Mobility Devices: Wheelchairs-Powered, With or Without Power Seating Systems and Power Operated Vehicles (POVs)
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Gender Reassignment Surgery
- GU Conditions
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable Infusion Pumps
- Implantable Middle Ear Hearing Aids
- Implantable or Wearable Cardioverter-Defibrillator
- Implanted Devices for Spinal Stenosis
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar Spinal Fusion and Lumbar Total Disc Arthroplasty
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Occipital Nerve Stimulation
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty

- Photocoagulation of Macular Drusen
- Plastic/Reconstructive Surgeries:
  - ► Abdominoplasty, Panniculectomy, Diastasis Recti Repair
  - ► Blepharoplasty
  - ► Brachioplasty
  - ► Buttock/Thigh Lift
  - ► Chin Implant, Mentoplasty, Osteoplasty Mandible
  - ► Insertion/Injection of Prosthetic Material Collagen Implants
  - ► Liposuction/Lipectomy
  - ► Procedures Performed on Male or Female Genitalia
  - ► Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
  - ► Procedures Performed on the Trunk and Groin
  - ► Repair of Pectus Excavatum / Carinatum
  - ► Rhinoplasty
  - ► Skin-Related Procedures
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing
- Radiation Therapy
  - ► Intensity Modulated Radiation Therapy (IMRT)
  - ► Proton Beam Therapy
  - ► Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Ablative Treatments for Chronic Headaches
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other
- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Tonsillectomy for Children with or without Adenoidectomy
- Total Ankle Replacement
- Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- Transcatheter Uterine Artery Embolization
- Transmyocardial/Periventricular Device Closure of Ventricular Septal Defects
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Treatment of Hyperhidrosis
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Varicose Veins (Lower Extremities)
- Vagus Nerve Stimulation
- Viscocanalostomy and Canaloplasty

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admissions for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- All Outpatient services for the following:
  - ► Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - ► Donor Leukocyte Infusion

Out-of-Network Referrals:

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

Mental Health/Substance Abuse:

Pre-certification Required

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care

Out-of-Network Referrals:

Out-of-Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or medical necessity.)

The following services do not require precertification, but are recommended for pre-determination of Medical Necessity due to the existence of post service claim review criteria and/or the potential cost of services to the Member if denied by for lack of Medical Necessity: Procedures, equipment, and/or specialty infusion drugs which have Medically Necessary criteria determined by the Claims Administrator's Medical Policy or Clinical Guidelines.

Utilizing a Provider outside of the Network may result in significant additional financial responsibility for You, because Your health benefit plan cannot prohibit Out-of-Network Providers from billing You for the difference between the Provider's charge and the benefit the Plan provides.

The ordering Provider, facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is Responsible for Precertification?

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

Provider Network Status	Responsibility to Get Precertification	Comments
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.	Provider	• The Provider must get Precertification when required
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.
Blue Card Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed,	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. • **Blue Card 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 the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time.		

The Claims Administrator will utilize its 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". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right 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 Identification Card.

If You are not satisfied with the Plan's decision under this section of Your benefits, please refer to the **Your Right To Appeal** section to see what rights may be available to You.

Decision and Notice Requirements

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on Federal laws. You may call the phone number on the back of your Identification Card for more details.

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
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 the request
Non-urgent Continued Stay/Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

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

The Claims Administrator will notify You and Your Provider of its decision as required by 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 sole 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 a process, Provider or Claim is exempted 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 Identification Card.

The Claims Administrator 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 the Claims Administrator 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

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

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

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

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

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

BENEFITS

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

Acupuncture

Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Ambulance Service

Medically Necessary Ambulance Services are a Covered Service when:

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

And one or more of the following criteria are met:

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

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

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

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

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

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

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

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Assistant Surgery

Services rendered by an assistant surgeon are covered based on Medical Necessity.

Behavioral Health Care and Substance Abuse Treatment

See the **Schedule of Benefits** for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.

- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:

  - observation and assessment by a psychiatrist weekly or more often; and
  - rehabilitation, therapy, and education.

- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs.

- **Online Visits** when available in Your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions. Online visits are not covered from Providers other than those contracted with LiveHealth Online.

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

- Psychiatrist;
- Psychologist;
- Licensed Clinical Social Worker (L.C.S.W.);
- Mental health clinical nurse specialist;
- Licensed Marriage and Family Therapist (L.M.F.T.);
- Licensed Professional Counselor (L.P.C); or
- Any agency licensed by the state to give these services, when they have to be covered by law.

Breast Cancer Care

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

Breast Reconstructive Surgery

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

Cardiac Rehabilitation

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

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

    a. The National Institutes of Health.

    b. The Centers for Disease Control and Prevention.

    c. The Agency for Health Care Research and Quality.

    d. The Centers for Medicare & Medicaid Services.

    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

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

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

        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

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

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

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

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

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

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

1. The Experimental/Investigative item, device, or service; or

2. Items and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Consultation Services

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

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

Dental Services

Related to Accidental Injury

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

Treatment must be completed within the timeframe shown in the **Schedule of Benefits**.

Other Dental Services

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- the Member is under the age of five (5);
- the Member has a severe impairment that requires hospitalization or general anesthesia for dental care; or
- the Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes

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

Dialysis Treatment

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

Durable Medical Equipment

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

The equipment must meet the following criteria:

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

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

Emergency Services

Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care including a medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical or behavioral health examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan.

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

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:

- the amount negotiated with Network Providers for the Emergency service furnished;
- the amount for the Emergency Service calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
- the amount that would be paid under Medicare for the Emergency Service.

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

General Anesthesia Services

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

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

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

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

Habilitative Services

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

Home Health Care Services

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

Some special conditions apply:

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

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Private Duty Nursing care;
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.

- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- services and/or supplies which are not included in the Home Health Care plan as described;
- services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse;
- any services for any period during which the Member is not under the continuing care of a Physician;
- convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member;
- any services or supplies not specifically listed as Covered Services;
- routine care and/or examination of a newborn child;
- dietician services;
- maintenance therapy;
- dialysis treatment; or
- purchase or rental of dialysis equipment.

Hospice Care Services

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

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

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

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

Hospital Services

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

Network

Inpatient Services

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

Service and Supplies

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

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

Hospital Benefits

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

Hospital Visits

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

Human Organ and Tissue Transplant Services

Notification

To maximize Your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

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

Covered Transplant Benefit Period

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

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

Prior Approval and Precertification
In order to maximize Your benefits, the Claims Administrator strongly encourages You to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Member Services telephone number on the back of Your Identification Card **and ask for the transplant coordinator.** Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

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

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

Licensed Speech Therapist Services
Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits.** Speech therapy is not covered when rendered for the treatment of Developmental Delay.

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

Maternity benefits are provided for a female Teammate or female Spouse of the Teammate. Dependent daughter maternity is also covered.

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

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

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits

within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member's attending Physician.

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

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

Infertility Services
Your Plan also includes benefits for the diagnosis and treatment of Infertility. Covered Services include diagnostic and exploratory procedures to determine whether a Member suffers from Infertility. This includes surgical procedures to correct any diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. Covered fertilization services include artificial insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), or ZIFT (zygote intra-fallopian transfer) procedures. See the **Schedule of Benefits** for benefit limitations, Coinsurance and Copayment amounts.

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

Medical Care
General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

Nutritional Counseling
Nutritional counseling related to the medical management of a disease state as stated in the **Schedule of Benefits**.

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

Online Visits
When available in Your area, Your coverage will include online visits from a LiveHealth Online Provider. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See **Schedule of Benefits** for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. For Behavioral Health and Substance Abuse Online Visits, see the "Behavioral Health Care and Substance Abuse Treatment" section. Online visits are not covered from Providers other than those contracted with LiveHealth Online. Non-Covered Services include, but are not limited to, communications used for:

- reporting normal lab or other test results;
- office appointment requests;
- billing, insurance coverage or payment questions;

- requests for referrals to Physicians outside of the online care panel;
- benefit precertification; and
- Physician to Physician consultation.

Oral Surgery

Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan and performed within the timeframes shown in the **Schedule of Benefits** after the accident.

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

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

Other Covered Services

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

- chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- diagnostic x-ray and laboratory procedures;
- dressings, splints and casts when provided by a Physician;
- oxygen, blood and components, and administration;
- pacemakers and electrodes; or
- use of operating and treatment rooms and equipment.

Out-of-Network Freestanding Ambulatory Facility

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

Out-of-Network Hospital Benefits

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

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Outpatient Hospital Services

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

Outpatient Surgery

Network Hospital outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under "Hospital Services".

Physical Therapy, Occupational Therapy, Manipulation Therapy

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

Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements. Consultations between your Primary Care Physician and a Specialty Care Physician are included, when approved by Anthem.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA). This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when You use a Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under Diagnostic services instead of this benefit, if the coverage does not fall within ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

   a. breast cancer;
   b. cervical cancer;
   c. colorectal cancer;
   d. high blood pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. child and adult obesity.

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

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

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

   a. Women's contraceptives, sterilization procedures, and counseling. This includes Generic oral contraceptives, injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to Your attending

Provider, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

c. Gestational diabetes screening.

5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:

   a. counseling;

   b. Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy; and

   c. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy, when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

   Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

   a. aspirin;

   b. folic acid supplement;

   c. vitamin D supplement; and

   d. bowel preparations.

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

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

Prosthetic Appliances

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

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

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

Reconstructive Surgery

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

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

Retail Health Clinic

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

Skilled Nursing Facility Care

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

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

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

Covered Services include:

- semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- Physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

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

Benefits will not be provided when:

- a Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- no specific medical conditions exist that require care in a Skilled Nursing Facility; or
- the care rendered is for other than Skilled Convalescent Care.

Surgical Care

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

Treatment of Accidental Injury in a Physician's Office

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

Prescription Drugs Administered by a Medical Provider

This Plan covers Prescription Drugs including Specialty Drugs, that must be administered to You as part of a Doctor's visit, home care visit, or at an outpatient facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that

must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to You in a medical setting. Benefits for Drugs that You inject or get through Your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefits at a Retail or Home Delivery (Mail Service) Pharmacy" section.

Important Details About Prescription Drug Coverage
Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Doctor may be asked to give more details before the Plan decides if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem Prescription Drug List (a formulary developed by the Claims Administrator which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Precertification
Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will give the results of the Plan's decision to both You and Your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of Your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section **Health Care Management - Precertification** for more details.

If precertification is denied You have the right to file an appeal as outlined in the **Your Right To Appeal** section of this Benefit Booklet.

Designated Pharmacy Provider
The Plan in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider's office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient

Care coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider's office.

You may also be required to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. The Plan reserves the right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. The Plan may from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in the Plan's discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at www.anthem.com.

Prescription Drug Benefits at a Retail or Home Delivery (Mail Service) Pharmacy

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

Benefits for Prescription Drugs, including Specialty Drugs, which are administered to You by a medical Provider in a medical setting (e.g., Physician's office, home care visit, or outpatient facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Your plan also includes benefits for Prescription Drugs You get at a Retail or Mail Order Pharmacy. The Pharmacy benefits available to You under this Plan are managed by the Claims Administrator's Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which the Claims Administrator contracts to manage Your Pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Home Delivery (Mail Service) Pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating the covered Prescription Drug list (also known as a Formulary) establishing a network of retail pharmacies and operating a Home Delivery (Mail Service) Pharmacy. The PBM, in consultation with the Claims Administrator also provides services to promote and enforce the appropriate use of Pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on Your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Claims Administrator can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Plan or utilization guidelines.

Prescription Drug benefits may require prior authorization to determine if Your Drugs should be covered. Your Network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for the Plan to decide benefits.

Prior Authorization
Prescribing Providers must obtain prior authorization in order for You to get benefits for certain Drugs. At times Your Provider will initiate a prior authorization on Your behalf before Your Pharmacy fills Your Prescription. At other times, the Pharmacy may make You or Your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of a Prescription Drug List (as described below).

You or Your Provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

The Plan may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in its sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

If prior authorization is denied You have the right to file an appeal as outlined in the **Your Right To Appeal** section of this Benefit Booklet.

The Plan keeps a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. The Plan may require You or Your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy

When you use the PBM's Specialty Pharmacy its patient care coordinator will work with You and Your Doctor to get prior authorization and to ship Your Specialty Drugs to Your home or Your preferred address. Your patient care coordinator will also tell You when it is time to refill Your prescription.

You can get the list of covered Specialty Drugs by calling Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at www.anthem.com.

Maintenance Pharmacy
You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure the Prescription Drug You are taking is a Maintenance Medication or need to determine if Your Pharmacy is a Maintenance Pharmacy, please call Member Services at the number on the back of Your Identification Card or check the Claims Administrator's website at www.anthem.com for more details.

Covered Prescription Drug Benefits
To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under Federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and You must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Benefits are available for the following:

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs are covered when obtained through an eligible Pharmacy. Emergency contraceptives, including Plan B are covered. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.
- Certain supplies and equipment obtained by Home Delivery (Mail Service) or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact the Plan to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Home Delivery (Mail Service) or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. Benefits include FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These services will be covered under the "Preventive Care" benefit. Please see that section for further details.
- Compound Drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, and require a Prescription to dispense, and are not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Treatment of Onchomycosis (toenail fungus).
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.

Non Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other Non-Covered Services)

- Drugs, devices and products, or Prescription Legend 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. This Exclusion does not apply to over-the-counter products that the Plan must cover under Federal law with a Prescription.
- Off label use, except as otherwise prohibited by law or as approved by the Plan or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including, but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a Prescription by Federal law (including Drugs requiring a Prescription by state law, but not by Federal law), except for injectable insulin.
- Drugs in quantities, which exceed the limits established by the Plan, or which exceed any age limits established by the Plan.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, and 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.
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact the Plan for additional information on these Drugs.
- Prescription Drugs prescribed by a Provider that does not have the necessary qualifications and including certifications as determined by the Claims Administrator.
- 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.
- Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- Charges for services not described in Your medical records.
- 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.
- Services determined to not be Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
- Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered 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.

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of Your scheduled Copayment/Coinsurance amount or the Maximum Allowed Amount. Please see the **Schedule of Benefits** for any applicable Coinsurance/Copayment. If You receive Covered Services from an Out-of-Network Pharmacy, a Coinsurance/Copayment amount may also apply.

Days Supply
Certain day supply limits apply to Prescription Drugs as listed in the **Schedule of Benefits**. In most cases, You must use a certain amount of your prescription before it can be refilled. In some cases the Plan may let You get an early refill. For example, the Plan may let You refill your prescription early if it is decided that You need a larger dose. The Claims Administrator will work with the Pharmacy to decide when this should happen.

If You are going on vacation and You need more than the day supply allowed, You should ask Your pharmacist to call the PBM and ask for an override for one early refill. If You need more than one early refill, please call Member Services at the number on the back of Your Identification Card.

Mandatory Generic
If You choose a Brand-Name Drug over a Generic Drug, regardless of whether a generic equivalent is available and even if the Physician orders the drug to be "dispensed as written", You will be responsible for the Copayment/Coinsurance for the Brand-Name Drug outlined in the **Schedule of Benefits**.

If You do not purchase a Generic Prescription Drug, when available, You must also pay the difference between the cost of the Generic Prescription Drug and the Brand Name Prescription Drug unless Your Physician has specified "dispensed as written".

Formulary
The Plan follows a drug Formulary in determining payment and Covered Services. You will be responsible for an additional Copayment amount depending on whether a Formulary or non-Formulary drug is obtained. Please see the **Schedule of Benefits**.

Tiers
Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.

Drugs are assigned to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. The Plan decides coverage for doses and administration (i.e., oral, injection, topical, or inhaled). The Plan may cover one form of administration instead of another, or put other forms of administration in a different tier.

Special Programs
Except when prohibited by Federal regulations (such as HSA rules), from time to time the Claims Administrator or the PBM may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Home Delivery (Mail Service) Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

Payment of Benefits
The amount of benefits paid is based upon whether You receive the Covered Services from a Network Pharmacy, an Out-of-Network Pharmacy, or the PBM's Home Delivery (Mail Service) Program. It is also based upon which Tier the Claims Administrator has classified the Prescription Drug. Please see the **Schedule of Benefits** for the applicable amounts, and for applicable limitations on number of days supply.

The Claims Administrator retains the right at the Claims Administrator's discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which You are responsible are shown in the **Schedule of Benefits**. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Copayment/Coinsurance for which You are responsible.

Your Copayment(s)/Coinsurance amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network Pharmacy or through the PBM's Home Delivery (Mail Service), You are responsible for all Copayment/Coinsurance amounts.

For Covered Services provided by an Out-of-Network Pharmacy, You will be responsible for the amount(s) shown in the **Schedule of Benefits**. This is based on the Maximum Allowed Amount.

How to Obtain Prescription Drug Benefits
How You obtain Your benefits depends upon whether You go to a Network or an Out-of-Network Pharmacy.

Network Pharmacy – Present Your written Prescription order from Your Physician and Your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file Your claim for You. You will be charged at the point of purchase for applicable Copayment/Coinsurance amounts. If You do not present Your Identification Card, You will have to pay the full retail price of the Prescription. If You do pay the full charge, ask Your pharmacist for an itemized receipt and submit it to the Plan with a written request for refund.

Important Note: If it is determined that You may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Network Providers for Controlled Substance Prescriptions may be limited. If this happens, the Plan may require You to select a single Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if You use the single Network Provider. The Claims Administrator will contact You if it is determined that use of a single Network Provider is needed and give You options as to which Network Provider You may use. If You do not select one of the Network Providers offered within 31 days, a single Network Provider will be selected for You. If You disagree with the Plan's decision, You may ask for reconsideration as it is outlined in the **Your Right to Appeal** section of this Benefit Booklet.

Specialty Drugs - You or Your Physician can order Your Specialty Drugs directly from a Specialty Network Pharmacy, simply call the Member Services telephone number on the back of Your Identification Card. If You or Your Physician orders Your Specialty Drugs from a Specialty Network Pharmacy, You will be assigned a patient care coordinator who will work with You and Your Physician to obtain Prior Authorization and to coordinate the shipping of Your Specialty Drugs directly to You or Your Physician's office. Your patient care coordinator will also contact You directly when it is time to refill Your Specialty Drug Prescription.

Out-of-Network Pharmacy – You are responsible for payment of the entire amount charged by the Out-of-Network Pharmacy. You must submit a Prescription Drug claim form to the Plan for reimbursement consideration. These forms are available from the Claims Administrator or from the Employer. You must complete the top section of the form and ask the Out-of-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, You must attach an itemized receipt to the claim form and submit to the Plan or the PBM. The itemized receipt must show:

- name and address of the Out-of-Network Pharmacy;
- patient's name;
- prescription number;
- date the Prescription was filled;
- name of the Drug;
- cost of the Prescription; and,
- quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the **Schedule of Benefits**. This is based on the Maximum Allowed Amount as determined by Anthem or the PBM's normal or average contracted rate with network pharmacies on or near the date of service.

The Home Delivery (Mail Service) Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written Prescriptions from Your Physician, or have Your Physician fax the Prescription to the PBM's Home Delivery (Mail Service). Your Physician may also phone in the Prescription to the PBM's Home Delivery (Mail Service) Pharmacy. You will need to submit the applicable Coinsurance and/or Copayment amounts to the PBM's Home Delivery (Mail Service) when You request a Prescription or refill.

LIMITATIONS AND EXCLUSIONS

These limitations and exclusions apply even if a qualified practitioner has performed or prescribed a Medically Necessary procedure, treatment or supply. This does not prevent your qualified practitioner from providing or performing the procedure, treatment or supply. Regardless, the procedure, treatment or supply will not be a covered expense.

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.
2. Services for Custodial Care.
3. Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.
4. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
5. Charges for treatment received before coverage under this option began or after it is terminated.
6. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated.
7. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.
8. Foot care only to improve comfort or appearance, routine care of corns, calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
9. Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary.
10. Treatment where payment is made by any local, state, or Federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
11. 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 Information.** 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.
12. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
13. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.
14. Outpatient prescription drugs prescribed by a Physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a

separate drug card program but not under this medical plan. Although coverage for outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.

15. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
16. Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
17. Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary.
18. Services for Hospital confinement primarily for diagnostic studies.
19. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an injury or to correct a congenital defect.
20. Donor Search/Compatibility, except as otherwise indicated.
21. Hearing aids, hearing devices or examinations for prescribing or fitting them.
22. Contraceptive Drugs, except for any above stated covered contraceptive devices.
23. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
24. Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this Benefit Booklet.
25. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
26. Christian Science practitioner services.
27. Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum and patches to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law.
28. Services provided in a halfway house.
29. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state or Federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.
30. Services or supplies provided by a member of your family or household.

31. Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator.
32. Fees or charges made by an individual, agency or facility operating beyond the scope of its license.
33. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
34. Services for any form of telecommunication, unless otherwise stated by the Plan.
35. Charges for any of the following:
    a. Failure to keep a scheduled visit;
    b. Completion of claim forms or medical records or reports unless otherwise required by law;
    c. For Physician or Hospital's stand-by services;
    d. For holiday or overtime rates.
    e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
    f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
36. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.
37. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is Your responsibility.Reversal of vasectomy or reversal of tubal ligation.
38. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes and/or which are performed as a treatment for acne.
39. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.
40. Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e. diabetes.
41. Vision surgery related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
42. Services for weight loss programs, services and supplies. Weight loss programs include, but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss).

43. Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
44. Vein Treatment - Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

CLAIMS PAYMENT

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

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

How to File Claims

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

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

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

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

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

Maximum Allowed Amount

General

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

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

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

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

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

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

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

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

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

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

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

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

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

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

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

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

For Covered Services rendered outside the Claims Administrator's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated price.

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

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

For Prescription Drugs: The Maximum Allowed Amount is the amount determined by the Claims Administrator using Prescription Drug cost information provided by the Pharmacy Benefits Manager (PBM).

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

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the

Schedule of Benefits in this Benefit Booklet for Your cost share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

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

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

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain Prescription Drug purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to Your Deductible, if any, or taken into account in determining Your Copayment or Coinsurance.

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

Services Performed During Same Session

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

Processing Your Claim

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

Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed

to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary Information

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

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

Claims Review

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

Notice of Claim & Proof of Loss

After You get Covered Services, we must receive written notice of Your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, You may have some extra time to file a claim. If we did not get Your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within **12** months), You may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 12 months after you get Covered Services will be denied, unless an extension is required by Federal law.**

Explanation of Benefits

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

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

Inter-Plan Arrangements

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever You access healthcare services outside the geographic area the Claims Administrator serves (the Anthem “Service Area”), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Anthem Service Area, You will receive it from one of two kinds of Providers. Most Providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield

Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types
Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, the Claims Administrator will still fulfill its contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for Your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process Your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If You receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Employer on Your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

E. Nonparticipating Providers Outside the Claims Administrator's Service Area

1. The pricing method used for nonparticipating provider claims incurred outside the Anthem Service Area is described in **Claims Payment.**

F. Blue Cross Blue Shield Global Core® Program

If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health Identification Card with You.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

If You need inpatient hospital care, You or someone on Your behalf, should contact the Claims Administrator for preauthorization. Keep in mind, if You need Emergency medical care, go to the nearest hospital. There is no need to call before You receive care.

Please refer to the **Health Care Management – Precertification** section in this Booklet for further information. You can learn how to get preauthorization when You need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core
In most cases, when You arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:
- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When You need Blue Cross Blue Shield Global Core claim forms You can get international claims forms in the following ways:
- Call the Blue Cross Blue Shield Global Core Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Unauthorized Use of Identification Card

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

Assignment

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

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

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

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Questions About Coverage or Claims

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

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- Provider name and address (Hospital or Physician).

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

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

An oral explanation of Your benefits by a Teammate of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

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

YOUR RIGHT TO APPEAL

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

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

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

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

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

Notice of Adverse Benefit Determination
If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:
- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA, if this Plan is subject to ERISA, within one year of the grievance or appeal 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 Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify You or Your authorized representative within 72 hours orally and then furnish a written notification.

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

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

For pre-service claims involving urgent/concurrent care, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:
- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

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

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

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

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:
- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

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

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

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

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

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

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

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

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

If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision 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 Claims Administrator 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 the Claims Administrator's control.

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

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

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

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

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

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

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

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

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

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this health care plan. There is no charge for You to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA, if this Plan is subject to 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 Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If Your health benefit plan is sponsored by Your Employer and subject to the Teammate Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA within one year of appeal decision.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

COORDINATION OF BENEFITS (COB)

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

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

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

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowed Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health Maintenance Organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or non group closed panel plans; group-type contracts; medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.
2. Plan does not include: Accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because You have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary high-Deductible health plan’s Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
7. Any amounts incurred or claims made under the Prescription Drug program of This Plan.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

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

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as a Teammate, Member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired Teammate), then the order of benefits between the two Plans is reversed so that the Plan covering You as a Teammate, Member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - the Plan covering the custodial parent;
     - the Plan covering the Spouse of the custodial parent;
     - the Plan covering the non-custodial parent; and then
     - the Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of items 1 or 2 above will determine the order of benefits as if those individuals were the parents of the child.

4. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouses plan, Rule 5 applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule in item 1 above to the Dependent child's parent(s) and the Dependent's spouse.

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

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

Determining the Allowable Expense When This Plan is Secondary to Medicare

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

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

SUBROGATION AND REIMBURSEMENT

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

Recovery
A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

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

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

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

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

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

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

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

GENERAL INFORMATION

Entire Agreement

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

Form or Content of Benefit Booklet

No agent or Teammate of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Circumstances Beyond the Control of the Plan

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

Protected Health Information Under HIPAA

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

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent Employer liability or indemnification law.

Other Government Programs

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

Medicare

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

Except when Federal law required us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to You shall be reimbursed by or on Your behalf to us, to the extent we have made payment for such services. 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.

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the plan year in which the error is discovered.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, The Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

Relationship of Parties (Employer-Member-Claims Administrator)

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

The Employer is fiduciary agent of the Member. The Claims Administrator's notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

Relationship of Parties (Claims Administrator - Network Providers)

The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or Teammates of the Claims Administrator, nor is the Claims Administrator, or any Teammate of the Claims Administrator, a Teammate or agent of Network Providers.

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

Anthem Health Plans of Virginia, Inc. Note

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

Notice

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

Modifications or Changes in Coverage

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

Fraud

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

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

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

Conformity with Law

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

Clerical Error

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

Policies and Procedures

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

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

Value-Added Programs

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

Waiver

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

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

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

Governmental Health Care Programs

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

Medical Policy and Technology Assessment

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

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

Payment Innovation Programs

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

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

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

Care Coordination

The Plan pays Network Providers in various ways to provide Covered Services to You. For example, sometimes the Plan may pay Network Providers a separate amount for each Covered Service they provide. The Plan may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Plan may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Plan may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Plan because they did not meet certain standards. You do not share in any payments made by Network Providers to the Plan under these programs.

Program Incentives

The Plan may offer incentives from time to time, at its discretion, in order to introduce You to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, and encouraging You to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. The Plan may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, it is recommended that You consult Your tax advisor.

Confidentiality and Release of Information

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

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

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

WHEN COVERAGE TERMINATES

Termination of Coverage (Individual)

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

Coverage of an enrolled child ceases at the end of the month when the child attains the age limit shown in the **Eligibility** section. Coverage of an impaired child over age 26 ceases if the child is found to be no longer totally or permanently impaired.

Coverage of the Spouse of a Subscriber terminates at the end of the month as of the date of divorce or death.

Continuation of Coverage (Federal Law-COBRA)

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

Qualifying Events for Continuation Coverage Under Federal Law (COBRA)

COBRA continuation coverage is available when Your group coverage would otherwise end because of certain “qualifying events.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your Spouse and Your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of Your family who is enrolled in the company’s Teammate welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

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

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

If You are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your Employer, and that bankruptcy results in the loss of coverage, You will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

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

Notification Requirements
In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled

Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, You or an eligible family member must make an election within 60 days of the date Your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies You or Your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage You choose to continue. If the Premium rate changes for active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than 102% of the Premium charged for Teammates with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

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

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

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

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

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

If You Have Questions
Questions concerning Your Group's health Plan and Your COBRA continuation coverage rights should be addressed to the Employer. For more information about Your rights under ERISA, if this Plan is subject to ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department

of Labor's Teammate Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage During Military Leave (USERRA)

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

Under USERRA, if the Teammate (or his or her Dependents) is covered under this Plan, and if the Teammate becomes absent from employment by reason of military leave, the Teammate (or his or her Dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that the Teammate is gone on military leave, the Teammate must give reasonable notice to the Employer of his or her military leave and the Teammate will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Teammate and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Teammate to apply for or return to work with the Employer. During military leave the Teammate is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Teammate's absence is less than 31 days, the Employer must continue to pay its portion of the premiums and the Teammate is only required to pay his or her share of the premiums without the COBRA-type 2% administrative surcharge.

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

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

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

- the birth of the Teammate's child;
- the placement of a child with the Teammate for the purpose of adoption or foster care;
- to care for a seriously ill Spouse, child or parent; or,
- a serious health condition rendering the Teammate unable to perform his or her job.

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

If membership in the Plan is discontinued for non-payment of premium, the Teammate's coverage will be restored to the same level of benefits as those the Teammate would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible Dependents.

The Teammate will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

For More Information

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

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

For more information about Your rights under ERISA, if this Plan is subject to ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Teammate Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at *www.dol.gov/ebsa.*

DEFINITIONS

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

Administrative Services Agreement
The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan. This Benefit Booklet in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control.

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

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

Behavioral Health Care
Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Biosimilar/Biosimilars
A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Brand Name Drug
The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (Generic).

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

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

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

Coinsurance
Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after You meet your Deductible. For example, if Your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, Your Coinsurance would be $20 after You meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the **Schedule of Benefits** for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

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

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

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

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

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

Controlled Substances
Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

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

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

rendered and are typically collected by the Provider when services are rendered. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

Cosmetic Surgery

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

Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the **Eligibility** section of this Benefit Booklet, has enrolled in the Plan, and is subject to administrative service fee requirements set forth by the Plan.

Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure

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

Custodial Care

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

Deductible

The portion of the bill You must pay before Your medical expenses become Covered Services. It usually is applied on a plan year basis.

Dependent

The Spouse and all children until attaining age limit stated in the **Eligibility** section. Children include natural children, legally adopted children, foster children that live with the Teammate and for whom the Teammate is the primary source of financial support, and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree.

Mentally, intellectually or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The

certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

Designated Pharmacy Provider

A Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with the Claims Administrator or a Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Detoxification

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

Developmental Delay

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

Durable Medical Equipment

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

Effective Date

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

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Emergency Medical Condition

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

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

Employer

An Employer who has allowed its Teammates to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

Experimental/Investigative

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

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

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

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

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

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

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

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

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

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

- medical records; or

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

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

Formulary

A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to (1) a listing of preferred Prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator, and are dispensed to Members through pharmacies that are Network Providers, and (2) Precertification rules. This list is subject to periodic review and modification. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Formulary.

Freestanding Ambulatory Facility

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

Generic Drugs

Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicates those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

Group Health Plan or Plan

A Teammate welfare benefit plan (as defined in Section 3(1) of ERISA), established by the Employer, in effect as of the Effective Date.

Home Delivery (Mail Service)

A Prescription Drug program which offers a convenient means of obtaining maintenance medications by mail if the Member takes Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Home Delivery (Mail Service), which has entered into a reimbursement agreement with the Claims Administrator and sent directly to the Member's home.

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

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

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

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

Hospital
An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

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

Ineligible Charges
Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

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

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

Initial Enrollee
A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury
Bodily harm from a non-occupational accident.

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

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

Intensive Outpatient Programs
Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Interchangeable Biologic Product
A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, is expected to produce the same clinical result as the reference product in any given patient.

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

Maintenance Pharmacy
A Network Retail Pharmacy that is contracted with the PBM to dispense a 90 day supply of Maintenance Medication.

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

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

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

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

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

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

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

Network Provider
A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements. A Network Provider for one plan may not be a Network Provider for another. Please see "How to Find a Provider in the Network" in the section **How Your Plan Works** for more information on how to find a Network Provider for this Plan.

New Hire
A person who is not employed by the Employer on the original Effective Date of the Plan.

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

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

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

Out-of-Pocket Maximum
The maximum amount of a Member's Coinsurance payments during a given Plan year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

Partial Hospitalization Program
Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy
An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

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

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

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

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

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

Plan Year

The period of time beginning at 12:00 A.M. on June 1st, continuing through the following January, and ending on May 31st at 11:59 P.M. It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Prescription Drug (Drug) (Also referred to as Legend Drug)

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, as designated in the FDA's Orange Book*: Approved Drug Products with Therapeutic Equivalence Evaluations*, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin.

Prescription Order or Prescription

A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician

A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization

The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider

A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question if a Provider is covered, please call the number on the back of Your Identification Card.

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

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

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

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

Residential Treatment Center / Facility

A Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured Facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

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

Semiprivate Room

A Hospital room which contains two or more beds.

Skilled Convalescent Care

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

Skilled Nursing Facility

An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the by the Claims Administrator.

Specialist (Specialty Care Physician\Provider or SCP)

A Specialist is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs
Typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

Spouse
For the purpose of this Plan, a Spouse is defined as shown in the **Eligibility** section of this Benefit Booklet.

Teammate
A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Teammate is also called the Subscriber.

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

Transplant Providers

Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

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

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

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

Utilization Review
Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

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

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

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

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

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

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

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

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

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

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

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

Mental Health Parity and Addiction Equity Act

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

Special Enrollment Notice

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

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

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

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

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

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

IT'S IMPORTANT WE TREAT YOU FAIRLY

That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on Your Identification Card for help (TTY/TDD: 711). If You think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, You can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

.

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in Your language for free. Call the Member Services number on Your Identification Card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for Members with visual impairments. If You need a copy of this document in an alternate format, please call the Member Services telephone number on the back of Your Identification Card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
□□□□ □□□ □□ □□□ □□□□□ □□□ □□□ □□□□□ □□□ □□□□□ □□□□ □□□□□□□ □□ □□□□ □□□□ □□□□□□□ □□□ □□□□□(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD: 711)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ bédé dyí-bɛ̀dɛ̀ìn-dɛ̀ɔ̀ bɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé dé m̀ bídí-wùdùǔn bó pídyi. Đá méɓà jè gbo-gmɔ̀ Kpòɛ́ nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̂ɔ̃ kɔ̃ɛ bɛ́ m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
□□□□□ □□□□□□□□□□ □□ □□□□ □□□□□□ □ □□□□□ □□□□□ □□□□□□□ □□□□ □□□□□□ □□□□ □□□□□□□□□ □□□□ □□□□□ □□□□ □□□□□□ □□□□ □□□□□ □□□□□□□ □□□□□□ □□ □□□□□(TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိနိုင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka

Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tɔ̈ në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (Identification Card) για βοήθεια. (TTY/TDD: 711)

Gujarati
□□□ □□□□□ □□□□□□□ □□□□□□ □ □□□□□□ □□□ □□□ □□□□□□□□ □□□□□□ □□□□□ □□. □□□ □□□□ □□□□□ □□□□ □□□□□ □□□□ □□□□□□ □□□□□□ □□□□ □□ □□□ □□□. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
□□□□ □□□ □□ □□□□□□□ □□ □□□ □□□□ □□□□ □□□ □□□□□□ □□□ □□□□□□□ □□□□ □□ □□□□□□ □□□ □□□ □□ □□□ □□□□ ID □□□□□ □□ □□□□□ □□□□□□ □□□□ □□ □□□ □□□□□ (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
[illegible]
[illegible].
[illegible]
[illegible]. (TTY/TDD: 711)

Navajo
Bee ná ahoot’i’ t’áá ni nizaad k’ehjíníkáá a’doowol t’áá jíík’e. Naaltsoos bee atah nílíníígíí bee néého’dólzingo nanitiníígíí béésh bee hane’í bikáá’ áaji’ hodíílnih. Naaltsoos bee atah nílíníígíí bee néého’dólzingo nanitiníígíí béésh bee hane’í bikáá’ áají’ hodíílnih. (TTY/TDD: 711)

Nepali
[illegible] ID [illegible] (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
□□□□□□□□ □□□□ □□□□ □□□□ □□ □□□□□□□□ □□□ □□□ □□□□□ □□□□ □□□□□□ □□□ □□ □□□□□□ □□□ □□□ □□ □□□□ □□□□ □□□□ □□□□ □□□□□ □□□□□□□□□ □□□□ □□ □□□ □□□□ (TTY/TDD: 711)

Romanian
Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong Identification Card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די מעמבער באדינונגען נומער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. אויף אייער קארטל פאר הילף(TTY/TDD: 711)

Yoruba
O ní ẹtọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)