Virginia Private Colleges Benefits Consortium, Inc.

Health Plan Document
and
Summary Plan Description

PPO Plans 2-7 and 12

Amended and Restated Effective
January 1, 2024

Virginia Private Colleges Benefits Consortium, Inc.
Health Plan Document

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Section 1
Introduction

1.1 Introduction

The Virginia Private Colleges Benefits Consortium, Inc. Health Plan (the "Plan") shall be effective January 1, 2024. The Plan may be amended at any time, in whole or in part, by the Board of Directors.

The Plan has been approved by the Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc. ("VPC Benefits Consortium"). The Plan is intended to meet the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), and Section 501(c)(9) of the Internal Revenue Code of 1986 ("Code") and the Regulations promulgated thereunder, as amended from time to time ("Section 501(c)(9)"). The VPC Benefits Consortium is authorized by Section 23.1-106 of the Code of Virginia, which allows certain institutions of higher education in the Commonwealth of Virginia to form a higher education benefits consortium.

This document and any amendments constitute the governing document of the Plan. This Plan is a multiple employer plan, designed and administered exclusively for the Members of VPC Benefits Consortium. Employees are entitled to this coverage if the provisions in the Plan have been satisfied. This Plan is void if Participant ceases to be entitled to coverage. No clerical error shall invalidate such coverage if otherwise validly in force.

The Board of Directors intends to maintain the Plan indefinitely. However, the Board of Directors has the right to modify the Plan at any time, and for any reason, as to any part or in its entirety, without advance notice. Likewise, the Board of Directors has the right to terminate the Plan at any time, and for any reason, upon 90 days' notice to the Members. If the Plan is amended or terminated, the Participant may not receive benefits described in the Plan after the Effective Date of such amendment or termination. Any such amendment or termination shall not affect Participant's right to benefits for claims incurred prior to such amendment or termination. If the Plan is amended, a Participant may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA benefits. This may happen at any time. If this Plan is terminated, the Participant will not be entitled to any vested rights under the Plan.

Important Phone Numbers

Anthem Member Services

By Telephone: 833-597-2358

CarelonRx Pharmacy Member Services

Customer Service: 833-389-1968

Virginia Private Colleges Benefits Consortium, Inc.

Tim Klopfenstein, Executive Director: 540-525-9693

24/7 NurseLine

Participants have access to a team of nurses, available to assist with questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms You're experiencing, how to get the right care in the right setting and more, and Participants can call as often as needed.

By Telephone for all Members: 800-337-4770

Advice on Reading this Document.

Defined Terms. Some of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this Document or in other relevant Sections. Becoming familiar with the terms defined in the Glossary will give Participant a better understanding of the procedures and benefits described.

Availability of Plans. While this document contains different PPO plan designs as reflected in the associated Summaries of Benefits and Coverage (hereinafter "SBCs") and Summaries of Benefits (hereinafter "SOBs"), only the PPO plan(s) offered by a Member college are available to the Employees of the Member college. If You have any questions about which plans are available to Employees at Your Member college, please contact Your Human Resources Department.

Summary Plan Description. This Plan Document and the associated SBCs and SOBs constitute the Plan Document and Summary Plan Description required by ERISA Section 102. Should the terms of this Plan Document and Summary Plan Description conflict with the terms of the associated SBCs or SOBs, the terms of the associated SBCs or SOBs will control, unless superseded by applicable law.

Section 2
Plan Identifying Information

Name of the Plan	Virginia Private Colleges Benefits Consortium, Inc. Health Plan (the "Plan")
Type of Plan	Health and Welfare Plan
Funding Medium and Type of Plan Administration	Anthem Blue Cross and Blue Shield ("Anthem") is the Medical Claims Administrator under the Plan. CarelonRx provides Pharmacy Benefit Management services. CarelonRx does not serve as an insurer, but merely as claims processor. The address of Anthem Blue Cross and Blue Shield is: P.O. Box 27401, Richmond, VA 23279. The address of CarelonRx is: PO Box 52065, Phoenix, AZ 85072. The VPC Benefits Consortium receives contributions from Members and Participants, and holds those assets in trust for the exclusive benefit of Participants and Dependents. Claims are paid out of these assets. To further protect the Plan from catastrophic losses, the Consortium has purchased excess liability insurance in the form of a stop-loss insurance policy.
Address of Plan	Virginia Private Colleges Benefits Consortium, Inc. 1 Cedar Hill Court, Suite D Bedford, VA 24523 (540) 525-9693
Plan Administrator and Agent for Service of Legal Process	Tim Klopfenstein Virginia Private Colleges Benefits Consortium, Inc. 1 Cedar Hill Court, Suite D Bedford, VA 24523 (540) 525-9693
Plan Number	501
Plan Sponsor and its IRS Employer Identification Number	Virginia Private Colleges Benefits Consortium, Inc. EIN: 27-1367957
Plan Effective Date	January 1, 2012
Amended and Restated Effective Date	January 1, 2024

Plan Renewal Date	January 1st	
Plan Year End	December 31st	
Named Fiduciary	The Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc.	
Preauthorization Providers	Anthem Blue Cross and Blue Shield CarelonRx	
Board of Directors	**President**:	Ken Copeland
	Vice-President:	Don Aungst
	Secretary:	Kim Harper
	Treasurer:	Holli Harman
	Executive Director:	Tim Klopfenstein

Section 3
The Provider Network

3.1 ID Card

The Anthem Blue Cross and Blue Shield ID card identifies the Participant as a Covered Person and contains important health care coverage information. When the Participant shows the ID card to a Doctor, Hospital, Pharmacist, or Other Professional Provider, the health care provider will file a claim for the Participant in most cases. Participants should carry their ID card at all times to ensure that he or she always has this coverage and information when needed. All Participants will receive an Anthem ID card. The SBC and SOB for Your plan of benefits and Your pharmacy benefits is found in an Appendix to this document.

3.2 Covered Providers and Facilities

The Plan covers certain care administered by providers and facilities. To ensure benefits, providers and facilities must be licensed in the state where they operate to perform the service received and the service must be covered by the Plan. Certain services are covered by the Plan and rendered by other covered medical suppliers, such as suppliers of Durable Medical Equipment, private duty nursing services, Prescription Drugs, ambulance services, etc.

A provider may delegate to an employee the responsibility for performing a Covered Service. The Plan will cover this care if it is determined that a bona fide employer-employee relationship exists, based on information given by the provider. Under these circumstances:

- Both the provider and the delegated employee must be licensed/certified to render the service;
- The service must be performed under the direct supervision of the provider since the provider is primarily responsible for the patient's care; and
- The provider who is directly supervising the service must bill for the service.

Because the service of the delegated employee is a substitute for the provider's service, the Plan will not pay a supervisory or other fee for the same service performed by both the provider and the delegated employee.

3.3 Primary Care Physicians and Specialty Care Providers

The Plan covers care provided by Primary Care Physicians and specialty care providers. Each Participant may use any In-Network Doctor who is a general or family practitioner, internist or pediatrician as his or her Primary Care Physician. The Plan also covers care provided by any specialty care provider the Participant chooses, including a behavioral health provider. Referrals are never needed to visit any specialty care provider.

3.4 Choosing a Health Care Provider

In Virginia. Each Participant has the freedom to receive care from any provider or facility. However, the Participant receives the highest level of benefits when receiving care from Participating Providers and facilities. The Plan provides coverage for certain services that do not have Participating Providers. These services would be considered In-Network services. (For example, private duty nursing services.)

Helpful tip: **Participants may call Member Services for information regarding the qualifications of Participating Providers. Qualifications include: medical school attended, residency completed, and board certification status.**

3.5 Out of Area Services

The Plan 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 are subject to the rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever the Participant obtains health care services outside of the Plan Service Area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which include the BlueCard Program and may include negotiated National Account arrangements available between the Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our Service Area, the Participant will obtain care from health care providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, the Participant may obtain care from non-participating health care providers. The Plan's payment practices in both instances are described below. Most claims are eligible to be processed through Inter-Plan Arrangements, except for prescription drugs that are obtained from a pharmacy and most dental or vision benefits.

3.6 The BlueCard® Program and Negotiated Arrangements for National Accounts

Under the BlueCard® Program, when the Participant accesses covered health care services within the geographic area served by a Host Blue, the Plan will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers. For certain Host Blues, instead of using the BlueCard Program, claims may be processed through negotiated arrangements for National Accounts.

Each Participant who will access covered health care services outside the Plan's Service Area and the claim is processed through the BlueCard Program, or through a negotiated National Account arrangement, the amount the Participant pays for covered health care services, is calculated based on the lower of:

- the billed covered charges for the Participant's Covered Services; or
- the negotiated price that the Host Blue makes available to the Plan.

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

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

Laws in a small number of states may require the Host Blue to add a surcharge to the Participant's calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Plan would then calculate the Participant's liability for any covered health care services according to applicable law.

If covered health care services are received under a value-based program inside of a Host Blue's service area, the Participant is not responsible for paying any of the provider incentives, risk-sharing, and/or case coordinator fees that are a part of such an arrangement, except where a Host Blue passes these fees to the Plan through average pricing or fee schedule adjustments.

Non-participating health care providers outside the Plan's Service Area

Member Liability Calculation. When covered health care services are provided outside of the Plan Service Area by non-participating health care providers, the amount the Participant pays for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state or federal law. In these situations, the Participant may be liable for the difference between the amount that the non-participating health care provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Helpful tip: In the event that **the Participant travels** outside of Virginia and **receives** services in a state with more than one Blue plan network, an exclusive network arrangement may be in place. If **the Participant sees** a provider who is not part of an exclusive network arrangement, that provider's **services** will be considered Out-of-Network care, and **the Participant** may be billed the difference between the charge and the **Allowable Charge. The Participant** may call Member Services or go to www.anthem.com for information regarding such arrangements.

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

3.7 Care Outside the United States – BlueCard® Worldwide

Before a Participant travels outside the United States, check with the Plan or call Customer Service at the number on the Identification Card to find out if the plan has BlueCard Worldwide benefits. Coverage outside the United States may be different from coverage in the United States, so it is suggested:

- Before leaving home, call the Customer Service number on the Identification Card for coverage details.
- Always carry an up-to-date identification card.
- In an emergency, go straight to the nearest Hospital. There is no need to call before You receive care.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- The Participant needs to find a Doctor or Hospital or needs health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- The Participant needs Inpatient Care. After calling the Service Center, the Participant must also call the Plan to get approval for benefits at the phone number on Your identification card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- Participating BlueCard Worldwide Hospitals. In most cases, when the Participant makes arrangements for a Hospital stay through BlueCard Worldwide, the Participant should not need to pay upfront for Inpatient Care at participating BlueCard Worldwide Hospitals except for the Out-of-Pocket Costs (non-Covered Services, Deductible, Copayments and Coinsurance) normally paid. The Hospital should send in the claim for the Participant.

- Doctors and/or non-participating Hospitals. The Participant will need to pay upfront for Outpatient services, care received from a Doctor, and Inpatient Care not arranged through the BlueCard Worldwide Service Center. Then the Participant can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- In most cases, the Hospital will file the Participant's claim if the BlueCard Worldwide Service Center arranged the Participant's Hospital stay. The Participant will need to pay the Hospital for the Out-of-Pocket Costs normally paid.
- The Participant must file the claim for Outpatient and Doctor care, or Inpatient Care not arranged through the BlueCard Worldwide Service Center. The Participant will need to pay the Provider and subsequently send an international claim form with the original bills to the Plan.

Claim Forms

The Participant can get international claim forms from the Plan, the BlueCard Worldwide Service Center, or online at www.bcbsglobalcore.com. The address for sending in claims is on the form.

3.8 Locating a Participating Provider

Participants may determine whether a provider or facility is In-Network by one of the following means:

- Referring to the plan's directory of Network providers at www.anthem.com, which lists Doctors and health care facilities that participate in the plan's Network, as well as information about the standards of care in area Hospitals;
- Call Anthem's Member Services to request a list of Doctors and health care facilities that participate in the plan's Network, based on specialty and geographic area;
- Contacting the Participant's Doctor or health care facility; or
- Contact the Plan Administrator.

All Participating Providers have a process in place to help the Participant get access to urgent Medical Care 24 hours a day, 7 days a week. If the Participant requires urgent Medical Care after his or her Doctor's normal business hours call the Doctor's office and the Participant will be directed to needed care.

Please note that not all In-Network providers offer all services. For example, some Hospital-based labs are not part of the Reference Lab Network. In those cases, the Participant will have to go to a lab in the Reference Lab Network to get In-Network benefits. Please call Member Services before getting services for more information.

3.9 Out-of-Network Care

Out-of-Network care is covered at a lower level of benefits than In-Network care. Once a Participant has satisfied a Calendar Year Deductible (if any), then the Participant is responsible for his or her Coinsurance, a percentage of the Allowable Charge as stated in the associated SBCs. If the Out-of-Network ambulance, provider or facility participates in any Anthem network or other Blue Cross Blue Shield company's network, they will accept the Allowable Charge as payment in full for their services. However, ambulances, providers and facilities that do not participate in any Anthem or Blue Cross Blue Shield company's network may bill Participant for the difference between their charge and the Allowable Charge.

Helpful tip: **Covered Services received during the last three months of the Calendar Year that are applied to a covered Participant's Deductible, may also apply to the medical Deductible (excluding the Prescription Deductible) required for the following Calendar Year.**

3.10 The Preauthorization Process

The Plan will make coverage decisions on services requiring Preauthorization (for example, Home Health Care Services), within 15 days from the receipt of the request. The Plan may extend this period for another 15 days if it is determined to be necessary because of matters beyond control. In the event that this extension is necessary, the Participant will be notified prior to the expiration of the initial 15-day period. If the coverage decision involves a determination of the appropriateness or Medical Necessity of services, the Plan will make its decision within 2 working days of its receipt of the medical information needed to process the Preauthorization request.

Preauthorization is required for the following treatments:

- All scheduled Hospital admissions;
- Maternity Hospital admissions that exceed the 48 hour Hospital stay for an uncomplicated vaginal delivery and that exceed the 96 hour Hospital stay for an uncomplicated cesarean delivery;
- Emergency Hospital admissions (within 48 hours of admission);
- Skilled Nursing Facility admissions;
- All confinements of newborn Dependents which extend beyond the mother's discharge date;
- All proposed CT Scans, Magnetic Resonance Imaging ("MRI") and related diagnostic procedures;
- Prescription Drugs; and

  Preauthorization may be required for certain prescription drugs in order to determine coverage. If the Participant does not obtain a Preauthorization, or if the Preauthorization is denied, a prescription drug may not be covered, or it may be at a higher cost to the Participant.

  As a part of the Preauthorization process for certain prescription oncology drugs, limited genetic testing may be performed in order to determine the likelihood that a prescribed medication will be effective based on the individual's unique genetic makeup. If the Participant does not undergo the genetic testing, or if the Preauthorization is denied, a prescription drug may not be covered, or it may be at a higher cost to the Participant.

- Urgent Care visits.

  For Urgent Care Claims, coverage decisions will be completed and the Participant and the Participant's provider will be notified as soon as possible, but not later than 72 hours from receipt of the request. If insufficient information is submitted in order to review the claim, the Plan will ask the Participant or provider for the information needed within 24 hours of the receipt of the request, and the Plan will make its decision within 48 hours of receiving the information. If the requested information is not received within 48 hours of the Plan's request, the Plan will make its decision within 96 hours from the date of the Plan's request. In cases where the Hospital admission is an Urgent Care Claim, a decision will be made within 24 hours. The Participant's Doctor will be notified verbally of the decision within this time frame.

Once the Plan has made a coverage decision on services requiring Preauthorization, the Participant will receive written notification of the coverage decision. In the event of an Adverse Benefit Determination, the written notification will include the following:

- The specific reasons and the Plan provisions on which the determination is based;
- A description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- A description of the Participant's Plan appeal procedures and applicable time limits; and
- In the case of an Urgent Care Claim, a description of the expedited review process applicable to such claims.

If all or part of a Preauthorization request or Urgent Care Claim was denied, the Participant has the right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the Plan relied upon in making the coverage decision. If a coverage decision was based on Medical Necessity or the experimental nature of the care, the Participant is entitled to receive, upon request and at no charge, an explanation of the scientific or clinical basis for the decision as it relates to the Participant's medical condition. Please see Section 12 for additional information.

3.11 Approvals of Care Involving an Ongoing Course of Treatment/Concurrent Care

Network providers must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If the Participant is receiving care from an Out-of-Network provider and needs to receive an extension of a previously approved course of treatment, the Participant will be required to ask for the extension. The Participant should request the extension at least 24 hours prior to the end of the authorized time frame to avoid disruption of care or services. The Plan Administrator will notify the Participant of the coverage decision within 24 hours of request**.** Additional information relating to Ongoing Course of Treatment/Concurrent Care Claims is found in Section 12, Claims and Payments.

3.12 In an Emergency or if Specialty Care is Not Reasonably Available in the Network

In an Emergency, Participants should seek care from the nearest appropriate provider or medical facility. The Plan will not impose any administrative requirement or coverage limitation on Out-of-Network Emergency Services that is more restrictive than would be imposed on In-Network Emergency Services.

If specialty care is required and it is not available from a Participating Provider, the Participant's Primary Care Physician may contact Member Services in advance of the Participant receiving care to have the Out-of-Network services authorized.

3.13 Allowable Charges

Providers or Facilities	**Allowable Charges**
Providers within the Participant's Network	The Network allowance or provider's charge, whichever is less
Providers outside of the Participant's Network	The participating allowance or provider's charge, whichever is less
Network and participating facilities	The negotiated allowance or the facility's charge, whichever is less
Non-participating facilities located in Virginia	Anthem's non-participating allowance or the facility's charge, whichever is less

Providers or Facilities	Allowable Charges
Non-participating facilities located outside of Virginia	The amount Anthem determines to be reasonable for the services rendered
Non-provider, non-facility service	The amount Anthem determines to be reasonable for the services rendered

In the chart of Allowable Charges, the allowance for services and the reasonable charge for services are determined by Anthem and other Blue Cross Blue Shield companies at their sole discretion.

Another company may pay a claim on Anthem's behalf to a facility that participates in one of its Networks. When this occurs, the Allowable Charge will be the lower of the billed charges of the facility or the negotiated price that the company passes on to us. The negotiated price may be a simple discount of billed charges, an estimated final price that reflects future settlement with the facility, or an average expected savings from the facility or Network. The estimated or average price may have been adjusted to correct for over- or under-estimation of past prices or non-claim transaction costs.

If Anthem's negotiated compensation cannot be determined at the time the claim for the Covered Service is processed, Anthem will use the value of the last known negotiated compensation derived from its most recent settlement with the facility.

3.14 Allowable Charges for Surgical Services

Surgical services performed by a provider are Covered Services. The Plan will not pay separately for pre- and post-operative surgical services.

If more than one surgical procedure is performed during the same operation, the Allowable Charge for all of the services combined will be calculated by adding:

- The Allowable Charge for the service with the highest Allowable Charge; plus
- A reduced percentage of what the Allowable Charge would have been for each of the additional surgical services if these services had been performed alone.

This is the most the Plan will pay during a single operation, unless extraordinary circumstances exist.

3.15 Assistant at Surgery

Services of a Doctor who actively assists the operating surgeon to perform surgical services are Covered Services. However, when two or more surgeons provide a surgical service that could have been performed by one surgeon, the Allowable Charge will not be more than that available to one surgeon.

3.16 Anesthesia

When surgical services require anesthesia, the anesthesia rendered by a second Doctor is a Covered Service. However, when the Doctor performs both the surgical service and the anesthesia, the Allowable Charge for the anesthesia will be 50% of what it would have been if a second Doctor had performed the anesthesia.

3.17 Hospital Admission Review

All Hospital stays, Skilled Nursing Facilities, or treatment in partial day programs should be approved before each admission ("Hospital Admission Review"). Maternity admissions do not initially require Hospital Admission Review if the stay does not exceed 48 hours for an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery; however, if complications develop and additional days

are necessary, Hospital Admission Review will be required. The Participant's Doctor may contact Anthem to establish eligibility and Waiting Periods regarding maternity admissions. If the Participant is admitted to the Hospital as a result of an emergency, the Participant's Hospital stay should be reviewed by Anthem within 48 hours of admission. The emergency room Doctor or someone authorized by the Participant can call for Hospital Admission Review. Network providers and facilities handle Hospital Admission Review for the Participant. The Participant must initiate the Hospital Admission Review process for Out-of-Network services. If the Participant fails to obtain approval for an Inpatient stay, and the stay is later determined not to be Medically Necessary, the Participant may have to pay the entire Hospital bill in addition to any charges for services provided while the Participant was an Inpatient. Strict adherence to this procedure may not be required for services that arise over the weekend.

Before the Participant is admitted to the Hospital for Medical Care or surgery, the Participant or someone authorized by the Participant must call the Member Services telephone number located on the Participant's identification card. Participants should have the following information available:

- The Participant's Anthem Blue Cross and Blue Shield identification number, located on the Participant's ID card;
- The Participant's Doctor's name and phone number;
- The date planned to enter the Hospital and length of stay; and
- The reason for Hospitalization.

Anthem will respond to a request for a Hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. Anthem may extend this period for another 15 days if we determine it to be necessary because of matters beyond their control. In the event that this extension is necessary, the Participant will be notified prior to the expiration of the initial 15-day period.

In cases where the Hospital admission is an Urgent Care Claim, a decision will be made within 24 hours. The Participant's Doctor will be notified verbally of the decision within this time frame.

Once a decision has been made regarding the Participant's Hospital admission, the Participant will receive written notification of the coverage decision. In the event of an Adverse Benefit Determination, the written notification will include the following:

- The specific reasons and the Plan provisions on which the determination is based;
- A description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- A description of the Plan's appeal procedures and applicable time limits; and
- In the case of an Urgent Care Claim, a description of the expedited review process applicable to such claims.

If all or part of a Hospital admission was not covered, the Participant has a right to receive, upon request and at no charge, any rule, guideline, protocol or criterion that the Plan relied upon in making the decision. If a decision was based on Medical Necessity or the experimental nature of the care, the Participant is entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to the Participant's medical condition. Please see Section 12 for additional information.

3.18 Admissions to Hospitals Located Outside of Virginia

If the Participant is admitted to a Hospital outside of Virginia, the Participant or someone on behalf of the Participant must initiate the Hospital Admission Review Process. This applies in all cases, whether the Participant lives, works, or travels outside of Virginia. If approval is not obtained for an Inpatient stay and the stay is later determined by Anthem not to be Medically Necessary, the Participant may have to pay the entire Hospital bill in addition to any charges for services provided while the Participant was an Inpatient.

3.19 Individual Case Management

In addition to the services listed, the Plan may elect to offer benefits for an approved alternate treatment plan for a patient who would otherwise require more expensive services. This includes, but is not limited to, long term Inpatient Care. The Plan will provide alternate benefits at its sole discretion. It will do so only when and for so long as it decides that the services are Medically Necessary and cost effective. The total benefits paid for such services may not exceed the total that would otherwise be paid without alternate benefits. If the Plan elects to provide alternate benefits for a Covered Person in one instance, it will not be required to provide the same or similar benefits for any Covered Person in any other instance. Also, this will not be construed as a waiver of the Plan's right to enforce the terms of the Plan in the future in strict accordance with its express terms.

Also, from time to time the Plan may offer a Covered Person and/or their provider or facility information and resources related to disease management and wellness initiatives. These services may be in conjunction with the Covered Person's medical condition or with therapies that the Covered Person receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

3.20 SurgeryPlus Benefit as an Alternative Surgical Option

The Plan offers an alternative option for certain surgical services, which may be utilized by Participants. SurgeryPlus is a supplemental benefit for planned, non-emergency surgeries, providing Participants with access to top-quality, affordable care for more than 1,500 surgical procedures.

By utilizing SurgeryPlus, Participants may be able to save money through reduced financial responsibility. SurgeryPlus has a nationwide network of over 400 hospitals and surgery centers to ensure Participants receive the proper care, from the right provider, and in the right location. The network is built with provider quality and surgical outcomes as the top priority. With an understanding of Participant care needs and preferences, the SurgeryPlus team will hand-select three surgeons for Participants to evaluate and choose from.

If You think You need surgery, SurgeryPlus has a dedicated team of Care Advocates that will provide a personalized experience, guiding Participants through the entire process. They will assist with finding a surgeon that meets the rigorous SurgeryPlus credentialing standards, coordinate logistics and any necessary travel arrangements, and ensure Participants have access to the best information when making decisions about surgical care. Covered procedure categories include (but are not limited to) orthopedics, spine, general surgery, gynecology, ear nose and throat, gastrointestinal, and cardiac. Participants in the SurgeryPlus Program shall receive a unique member identification number and card to present for SurgeryPlus services.

For more information and for the full list of available surgeries offered by SurgeryPlus, visit www.surgeryplus.com, email VPCBC@surgeryplus.com, or call 833-512-1174 to speak with a Care Advocate.

3.21 If Participant Changed Plans Within the Year

The Plan may include Calendar Year limitations on Deductibles, Out-of-Pocket Expenses, or benefits. These limitations may be affected by a change of Plan coverage during the Calendar Year.

- If the Participant changes from a non-VPC Benefits Consortium Member employer's health plan to this Plan during the Calendar Year, new limitations will apply as of the Effective Date of coverage under this Plan. Amounts that may have accumulated toward similar limitations under the Participant's former employer's Plan will not count toward the limitations under this Plan.
- If the Participant does not change employers, but moves from Anthem HealthKeepers coverage (issued by an Anthem-affiliated HMO) to Anthem coverage during the Calendar Year, new limitations will apply as of the Effective Date of the Participant's Anthem coverage. Amounts that may have accumulated toward specific Benefits or Out-of-Pocket requirements under the Anthem HealthKeepers will not count toward the limitations under the Anthem coverage.
- If the Participant does not change employers, but moves from non-Anthem coverage (issued by any other company) to Plan coverage during the Calendar Year, new limitations will apply as of the Effective Date of Plan coverage. Amounts that may have accumulated toward specific benefits or Out-of-Pocket requirements under the non-Anthem coverage will not count toward the limitations under the Plan coverage. However, in the course of moving to Plan coverage with the Employer, Participant may be eligible for credit of Deductible and/or Out-of-Pocket Maximum amounts accumulated under the non-Anthem coverage.
- If the Participant does not change employers or changes employment from one VPC Benefits Consortium Member to another Member, but moves from an Anthem benefit plan or option to this Plan during the Calendar Year, any amounts that had accumulated toward Calendar Year limitations before the change will count toward similar limitations under this Plan or option for the remainder of the Calendar Year.

Section 4
Enrollment and Contributions

4.1 Participant Enrollment

The "Effective Date" for the Employees of a Member shall be the first day of the month following or coinciding with the Employee's date of hire, provided that:

- **Enrollment**. The Employee meets the requirements for eligibility and properly enrolls in the Plan no later than 31 days following the Employee's date of hire;
  - Continuously meets the requirements for eligibility; and
- **Contributions**. The Member, Employee or Part Time Employee makes the required Contributions toward the cost of coverage for the Participant and any Covered Dependent(s). The formula used for allocating the required Contributions between the Member and its Employees must be approved by the Board of Directors. The amount of the respective Contributions shall be set forth in notices from the Plan Administrator and may be changed from time to time by the Board of Directors.

4.2 Dependent Enrollment

- **Initial Enrollment**. If the Dependent satisfies the definition of a "Dependent" in the Glossary and if a Participant properly enrolls the Dependent within 31 days of the date of hire, the Dependent's Effective Date shall be the same day as the Participant's Effective Date. A Disabled Child must meet the definition of a Disabled Child and satisfy the requirements for Initial Enrollment of a Disabled Child, both contained in the Glossary.
- **Later-Acquired Dependent**. If a Participant, after initial enrollment, acquires a new eligible Dependent, the Participant may complete, sign and return an application to the Plan Administrator within the period set forth below. If the newly acquired Dependents are enrolled within this period, the Effective Date of that Dependent's coverage is the first date in which the Dependent met the definition of Dependent.
  - **Newborn or Adopted Children (Special Enrollees).** Newborn and newly adopted children shall be covered for Injury or Illness from the moment of birth, adoption, or placement for adoption. Covered Services include the necessary care or treatment of medically diagnosed Congenital Defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent within **30 days** of the child's date of birth, adoption or placement for adoption. This provision shall not apply to or in any way affect the maternity coverage applicable to the mother.

    Actual Enrollment Necessary Upon Birth of Newborn, Adoption or Placement for Adoption. It is necessary to obtain, complete, sign and return a **new enrollment form** to add a newborn or adopted child to the Plan. If the Participant fails to complete, sign and return an enrollment form within **30 days** after birth of a newborn, adoption or placement of adoption, the Dependent **will not have coverage** or be able to enroll until the next Open Enrollment period. Claims for maternity expenses or maternity leave **do not** constitute notification or enrollment of a new Dependent for coverage.

  - **Siblings and Other Dependents Upon Birth or Adoption (Special Enrollee)**. If a Participant's other Dependents are not Covered Persons, the Participant may enroll these other Dependents along with a newborn or adopted child as described in the subsection above. If

the Participant enrolls the other Dependents within **30 days**, the Special Enrollment Date and coverage shall become effective on the child's date of birth, adoption, or upon placement for adoption.

- **Spouse Upon Marriage (Special Enrollee).** A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent within **31 days** of the date of marriage.
- **Court Order or Decree.** If a Dependent is acquired through a court order, decree, or marriage, that Dependent will be considered a Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled within **31 days** of the court order, decree, or marriage.
- **Qualified Medical Child Support Order.** A child may become eligible for coverage as set forth in a Qualified Medical Child Support Order. The Plan Administrator will establish written procedures for determining (and have sole discretion to determine) whether a medical child support order is qualified and for administering the provisions of benefits under the Plan pursuant to a Qualified Medical Child Support Order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.

- **Dependent Contributions**. A Participant or Dependent may be required to make periodic contributions toward the cost of the Dependent's coverage under the Plan in an amount determined by the Plan Administrator. The amount of the respective contributions shall be set forth in notices from the Plan Administrator, and may be changed from time to time by the Board of Directors.

4.3 Loss of Alternate Health Coverage (Special Enrollees)

A Participant or a Dependent who was previously eligible for coverage, but did not enroll because of alternate health coverage, may complete, sign and return an application to the Plan Administrator within the **31-day** Special Enrollment Period following the Participant or Dependent's loss of such other coverage (including coverage through the Marketplace) due to any of the following:

- Exhaustion of COBRA Continuation Coverage;
- Loss of eligibility for such other coverage due to divorce, legal separation, death, Termination of Employment or reduction of hours of employment;
- Termination of Employer contributions; or
- Reaching the lifetime limit on all benefits under the Eligible Employee's or Dependent's prior plan.

For a Disabled Child only, a significant cost increase of the Disabled Child's coverage through the Marketplace will constitute a loss of coverage and thus a special enrollment right for the Disabled Child, provided that the child meets the definition of a Disabled Child and satisfies the requirements for Special Enrollment of a Disabled Child, both contained in the Glossary.

Individuals who lose coverage due to nonpayment of premiums or for cause (e.g. filing fraudulent claims) shall not be Special Enrollees hereunder.

Coverage for a Special Enrollee hereunder shall begin as of the day following loss of alternate health coverage, but not more than 31 days prior to the date the enrollment application is received by the Plan Administrator.

4.4 Special Enrollment Based on Children's Health Insurance Program (CHIP)

Employees and Dependents who are eligible but not enrolled for coverage when initially eligible may become a Special Enrollee in two additional circumstances:

- The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
- The Employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

4.5 Change in Status

The Plan allows election changes outside of Open Enrollment based on certain change in status events. The cafeteria plan of the Member governs whether a corresponding mid-year change is allowed to a Participant's pre-tax salary reduction election. Participants should refer to the Member's plan document governing the cafeteria plan to determine whether pre-tax salary reduction elections can be changed for the following change in status events allowed under this plan:

- When a change in contribution is significant, a Participant may either increase the contributions or change to a less costly coverage election.
- When a new benefit option is added, a Participant may change to elect the new benefit option.
- When a significant overall reduction is made to a benefit option, a Participant may elect another available benefit option.
- A Participant may make a coverage election change if the Spouse or Dependent is covered as an Employee or Dependent under another employer plan and that plan incurs a change such as adding or deleting a benefit option and:
    - Allows a permitted mid-year election change; or
    - Allows election changes due to that Plan's annual Open Enrollment which does not coincide with this Plan's annual Open Enrollment.

4.6 Participant's and Dependent's Termination of Participation

A Participant and Dependent's participation under the Plan shall terminate on the earlier of the following occurrences:

- The end of the month in which the Participant Terminates Employment with a Member; unless the Member is obligated to continue to make contributions on behalf of such Participant by terms of the employment agreement between the Member and the Participant including the Member's personnel manual;
- The end of the month in which the Participant loses his status as a Participant, or the Dependent loses his status as a Covered Dependent;
- The Plan terminates;
- While on an Approved Leave of Absence or Approved Sabbatical, the Participant becomes employed full time by another employer and is eligible for health benefits;
- The failure to pay required contributions. In such case coverage shall terminate on the last date for which the required contributions were paid, as determined by the Plan Administrator;

- Upon a Participant's death, any Covered Dependent may remain a Dependent for the applicable period of Continuation Coverage set forth in the Continuation of Coverage Section, provided that the Covered Dependent complies with the conditions therein; or
- For cause (i.e. fraudulent claims).

4.7 Rescission of Coverage

The Plan Administrator reserves the right to rescind coverage under the Plan if an Employee, spouse or child becomes covered under this Plan or receives Plan benefits as a result of an act, practice or omission that constitute fraud or is due to the intentional misrepresentation of a material fact, both of which are prohibited by this Plan. Rescission is a cancellation and discontinuance of coverage, retroactive to the date the Employee, spouse or child became covered or received a Plan benefit as a result of fraud or the intentional misrepresentation of a material fact. The Plan Administrator will provide at least 30 days advance notice to an Employee, spouse or child of its intent to rescind coverage with an explanation of the reason for the intended rescission. The rescission shall not apply to benefits paid more than one year before the date of such advance notice. A cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage only has a prospective effect; or
- the cancellation or discontinuance of coverage is only retroactive to the extent it is attributable to the timely failure to pay Premiums (including COBRA Premiums) toward the cost of coverage; or
- the cancellation or discontinuance of coverage is initiated by an Employee, spouse or child (or the Employee, spouse or child's personal representative).

A rescission is subject to the claims payment and appeal procedures described in Article 12.

4.8 Open Enrollment

The Plan shall conduct Open Enrollment each Calendar Year. During Open Enrollment, Participants may make any of the following changes regarding participation in the Plan, subject to the other governing provisions of this Plan Document.

- Add Dependents not able to enroll during the Calendar Year as Special Enrollees or remove existing Dependents from coverage; and
- Change Plan options or such other changes as permitted by this Plan Document.

4.9 Eligible Retiree's Participation

An Eligible Retiree may participate in the Plan as of the date of retirement from a Member, subject to the following and any other applicable terms and conditions set forth in this Plan Document:

- If a Participant becomes an Eligible Retiree, such Eligible Retiree may continue as a Covered Person until the date the Eligible Retiree becomes eligible for Medicare;
- If an Eligible Retiree's Dependent is not a Covered Person on the day prior to the time the Participant becomes an Eligible Retiree, such Dependents may not thereafter become a Covered Person in the Plan unless the Dependent is a Special Enrollee (see Dependent Enrollment for further information);

- A Dependent spouse acquired by marriage or domestic partnership (where the Member has executed a Rider affording domestic partner coverage) after a Participant becomes an Eligible Retiree may become a Covered Person in the Plan as a Special Enrollee (see Dependent Enrollment for further information);
- If an Eligible Retiree or an Eligible Retiree's Dependent who was a Covered Person terminates participation in the Plan, such person may not thereafter become a Covered Person in the Plan unless the Dependent is a Special Enrollee (see Dependent Enrollment for further information);
- Upon an Eligible Retiree's death or termination of participation due to eligibility for Medicare, any Covered Spouse and Covered Child may remain a Covered Dependent until the earlier of the date of such Covered Spouse's death, termination of participation due to Medicare eligibility, or remarriage. An Eligible Retiree's Dependent who is eligible for Medicare may not be a Covered Person in the Plan.
- Upon an Eligible Retiree's death or termination of participation due to eligibility for Medicare, any Covered Spouse and Covered Child may elect to cancel or reduce their medical coverage at that time;
- Upon the death or retirement of a Participant who is Medicare eligible and who, except for such eligibility for Medicare, would qualify as an Eligible Retiree, any Covered Dependents may remain a Covered Dependent on the same basis as the Covered Dependents of an Early Retiree who is terminating due to death or eligibility for Medicare; and
- If an Eligible Retiree terminates participation in the Plan for any reason other than for death or eligibility for Medicare, the Covered Dependents of such Eligible Retiree shall terminate participation in the Plan as of the Eligible Retiree's termination of participation, at which time no Continuation Coverage shall be provided.

Section 5
Continuation of Coverage

COBRA Continuation Coverage is a temporary extension of group health coverage under the Plan. The right to COBRA Continuation Coverage was created by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Continuation Coverage can become available to Qualified Beneficiaries when group health coverage under the Plan ends.

This Section explains COBRA Continuation Coverage, when it may become available and what the Participants need to do to protect the right to receive it.

For additional information about the Participant's rights and obligations under the Plan and under Federal law, the Participant should contact the Plan Administrator.

5.1 COBRA Continuation Coverage

COBRA Continuation Coverage is available to "Qualified Beneficiaries," who are Covered Persons whose coverage would otherwise be lost because of a "qualifying event," as described below:

- **Participants.** A Participant may elect COBRA Continuation Coverage, (at the Participant's own expense plus a 2% administration fee) if the Participant's participation under the Plan terminates as a result of Termination of Employment or reduction of hours with a Member.
- **Gross Misconduct.** The Plan Administrator will not offer COBRA Continuation Coverage for the Participant or any of the Participant's Dependents where the Plan Administrator determines that the Termination of Employment was due to gross misconduct.
- **Dependents.** A Dependent may elect COBRA Continuation Coverage (at the Dependent's own expense plus a 2% administration fee) if the Dependent's participation under the Plan would terminate as a result of one of the following qualifying events:
    - Death of a Participant;
    - A reduction in hours of a Participant;
    - Termination of Employment of a Participant, except for a termination due to gross misconduct;
    - Divorce or legal separation from a Participant;
    - If the Participant cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and can establish that coverage was cancelled earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation;
    - A Dependent child ceases to qualify as a Dependent under the Plan; or
    - A Participant becomes entitled to Medicare.

Other individuals who may qualify for COBRA Continuation Coverage:

- **Recipients under Qualified Medical Child Support Orders.** A child of the Participant who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during the Participant's period of employment with Member is entitled to the same rights under COBRA as a Dependent child of the Participant, regardless of whether that child would otherwise be considered a Dependent.
- **Children Born To or Placed for Adoption During COBRA Period.** A child born to, adopted by or placed for adoption with a Participant during a period of Continuation Coverage is considered to be a Qualified Beneficiary provided that, the Participant has elected Continuation Coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Open Enrollment, and lasts for as long as COBRA coverage for other Qualified Beneficiaries of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan requirements.
- **Participants and Dependents after FMLA.** If a Participant takes leave under FMLA and does not return to work at the end of that leave, the Participant and any Dependents will be entitled to elect COBRA if:
  - They were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); or
  - They will lose Plan Coverage within 18 months because of the Participant's failure to return to work at the end of the leave.

  COBRA Continuation Coverage elected in these circumstances will begin on the last day of FMLA leave.

COBRA Continuation Coverage is the same coverage that the Plan gives to other Participants and their Dependents under the Plan that are not receiving COBRA Continuation Coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Participants or Dependents covered under the Plan, including Open Enrollment and Special Enrollment rights.

- **Duty to Notify Plan Administrator of Qualifying Events.** The Plan Administrator must be timely notified in writing that a qualifying event has occurred in order to be eligible for COBRA Continuation Coverage.
  - Notice must be given by the Employer within **30 days** of the following qualifying events:
    - Termination of Employment of a Participant;
    - Reduction of hours of a Participant;
    - Death of a Participant;
    - Participant becoming entitled to Medicare; or
    - Bankruptcy of Employer.
  - Notice must be given within **60 days** by the Qualified Beneficiary or its representative, for all other qualifying events not previously mentioned, following either:
    - The date of the qualifying event; or
    - The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

- If the Covered Person provides written notice that does not contain all of the information and documentation required, such notice will nevertheless be considered timely **if all of the following conditions are met**:
  - Notice is mailed or hand delivered by the deadline;
  - The Plan Administrator is able to determine the identity of the Employer, Participant and Qualified Beneficiaries, and the qualifying event from the Notice; and
  - The Notice is supplemented with the requested additional information and documentation to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator.

  If any of the above conditions are not met, the incomplete Notice will be rejected and COBRA will not be offered.

Caution: If these procedures are not followed or if written notice is not provided to the Plan Administrator within the specified time period, any Participant or Dependent who loses coverage will not be offered the option to elect Continuation Coverage.

***Notice Procedures*:** Any notice must be in writing. Oral notice, or notice by telephone, is not accepted. Participant must mail, e-mail or hand-deliver their notice to the Plan Administrator at this address:

Virginia Private Colleges Benefits Consortium, Inc.

Attn: Tim Klopfenstein
1 Cedar Hill Court, Suite D
Bedford, VA 24523
tim@vpcbc.org

If mailed, the Participant's notice must be postmarked no later than the last day of the specified time period. Any notice provided must state the name of the Plan *(*Virginia Private Colleges Benefits Consortium, Inc. Health Plan), the name and address of the Participant covered under the Plan, and the name(s) and address(es) of the Dependent(s) who lost coverage. Participant's notice must also state the qualifying event and the date it happened.

Forms: The Plan's Notice of Qualifying Event Form should be used to notify the Plan Administrator of a qualifying event. (A copy of this form can be obtained from the Plan Administrator.) If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Plan's Notice of a Second Qualifying Event (a copy of the form can be obtained from the Plan Administrator) must also state the event and the date it happened. If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Participant's Notice of Disability must also include the name of the disabled qualified Dependent, the date when the Dependent became disabled, the date the Social Security Administration made its determination. Participant's Notice of Disability must include a copy of the Social Security Administration's determination, and a statement as to whether or not the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled (a copy of this form can be obtained from the Plan Administrator).

- **Electing COBRA Continuation Coverage.** The following rules apply to COBRA election:
  - COBRA Continuation Coverage will begin on the date of the qualifying event for each Qualified Beneficiary who timely elects COBRA Continuation Coverage;
  - Each Qualified Beneficiary has an independent right to elect Continuation Coverage;
  - A Qualified Beneficiary must elect coverage in writing within 60 days of being provided a COBRA Election Notice, using the Plan's Election Form and following the procedures specified on the Election Form;
  - Written notice of election must be provided to the Plan Administrator at the address provided on the Plan's Election Form. If mailed, the election must be postmarked no later than the 60th day of the election time period;
  - A Participant or Dependent may change a prior rejection of Continuation Coverage at any time during the specified time period by providing the Notice of Election;
  - A Participant or Dependent who fails to elect Continuation Coverage within the specified time period will lose his or her right to elect Continuation Coverage; and
  - Unless otherwise indicated, an affirmative election of COBRA Continuation Coverage by a Participant shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.

    The Participant (i.e. the Employee or former Employee who is or was covered under the Plan), a Qualified Beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the Notice of Election on behalf of all Qualified Beneficiaries who lost coverage due to the qualifying event described in the Notice.

Note Regarding Failure to Elect. In considering whether to elect Continuation Coverage, Participant should take into account that a failure to continue their group health coverage will affect Participant's future rights under federal law.

First, the Participant can lose the right to avoid having preexisting condition exclusions applied to Participant by other group health plans if the Participant has a gap of 63 days or more in health coverage. Election of Continuation Coverage may help Participant avoid such a gap.

Second, the Participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if the Participant does not get Continuation Coverage for the maximum time available to the Participant.

Finally, the Participant should take into account that they have Special Enrollment rights under federal law. The Participant has the right to request Special Enrollment in another group health plan for which the Participant is otherwise eligible (such as a plan sponsored by the Participants spouse's employer) within 30 days after the Participant's group health coverage ends. The Participant will also have the same Special Enrollment right's at the end of Continuation Coverage if the Participant gets Continuation Coverage for the maximum time available to Participant.

- **Length of Continuation Coverage.** COBRA Continuation Coverage is a temporary continuation of coverage. The COBRA Continuation Coverage periods described below are maximum coverage periods.
- **Period of Continuation Coverage for Participants.** A Participant, who qualifies for COBRA Continuation Coverage as a result of Termination of Employment or reduction in hours of employment, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the qualifying event.

  Coverage under this Section may not continue beyond:

  - The date on which the Member ceases to maintain a group health plan;
  - The last day of the month for which the required contributions have been made;
  - The date the Participant becomes entitled to Medicare; or
  - The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by VPC Benefits Consortium, provided the new group plan does not have a preexisting condition limitation that affects the Participant.
  - COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Person not receiving COBRA Continuation Coverage (*i.e.* filing fraudulent claims).
- **Period of COBRA Continuation Coverage for Dependents.** If a Dependent elects COBRA Continuation Coverage under the Plan as a result of the Participant's Termination of Employment or reduction in hours of employment as described above, Continuation Coverage may be continued for up to 18 months measured from the date of the qualifying event. COBRA Continuation Coverage for all other qualifying events may continue for up to 36 months.

  In addition to maximum periods discussed immediately above, Continuation Coverage under this subsection may not continue beyond:

  - The last day of the month for which required contributions have been made;
  - The date the Dependent becomes entitled to Medicare;
  - The date which the Member ceases to maintain a group health plan; or
  - The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by the VPC Benefits Consortium provided that the new group plan does not have a preexisting condition limitation that affects the Dependent.

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Dependent not receiving COBRA Continuation Coverage (*i.e.* such as fraud).

- **Contribution Requirements for COBRA Continuation Coverage.** Participants and Dependents who elect COBRA Continuation Coverage as a result of one of the qualifying events specified must make Continuation Coverage Payments.

  Participants and Dependents must make the Continuation Coverage Payments monthly prior to the first day of the month in which such coverage will take effect. However, a Participant or Dependent has 45-days from the date of an affirmative election to pay the Continuation Coverage Payment for the period between the date medical coverage would otherwise have terminated due to the qualifying event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Participant and/or Dependent shall have a **31-day** grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the **31-day** grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which required contributions were made. The **31-day** grace period shall not apply to the **45-day** period for payment of COBRA premiums as set out in this Subsection.

- **Cost of COBRA Continuation Coverage.**

  - **Amount**. Each Qualified Beneficiary may be required to pay the entire cost of Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both Employer and Participant contributions) for coverage of a similarly situated Plan Participant who is not receiving Continuation Coverage, (or in the case of an extension of Continuation Coverage due to a Disability, 150%).

  - **Timely Payment of Premiums**. Participants and Dependents who elect COBRA Continuation Coverage as a result of one of the Qualifying Events specified above must make Continuation Coverage Payments.

    Participants and Dependents must make the Continuation Coverage Payment monthly prior to the first day of the month in which such coverage will take effect. However, a Covered Person has 45 days from the date of an affirmative election to pay the Continuation Coverage Payment for the period between the date medical coverage would otherwise have terminated due to the Qualifying Event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Participant and/or Dependent shall have a **31-day** grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the **31-day** grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which required contributions were made. The **31-day** grace period shall not apply to the **45-day** period for payment of COBRA premiums.

  - **Trade Act of 2002**. Two provisions under the Trade Act affect benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive an 80% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional **60-day** period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from

the beginning date of the second election period. Participants should consult the Plan Administrator if he or she believes the Trade Act applies to their situation.

- **Limitation on Participant's Rights to COBRA Continuation Coverage.**
  - If a Dependent loses, or will lose medical coverage, under the Plan as a result of a divorce or ceasing to be a Dependent, the Participant or Dependent is responsible for notifying the Plan Administrator within **60 days** of the divorce or loss of Dependent status. Failure to make timely notification will terminate the Dependent's rights to COBRA Continuation Coverage under this Section.
  - A Participant or Dependent must complete, sign and return the required enrollment materials within **60 days** from the later of:
    - Loss of coverage; or
    - The date the Plan Administrator or authorized representative of the Plan sends notice of eligibility for COBRA Continuation Coverage.

      Failure to enroll for COBRA Continuation Coverage during this 60-day period will terminate all rights to COBRA Continuation Coverage under this Plan. An affirmative election of COBRA Continuation Coverage by a Participant or Participant's spouse shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.
- **Second Qualifying Event.** If a second qualifying event which would entitle a spouse or Dependents to 36 months of Continuation Coverage occurs during an 18-month extension explained above, coverage may be continued for a maximum of 36 months from the date of the first qualifying event provided that the Qualified Beneficiary notifies the Plan Administrator within **60 days** of the second qualifying event. Such second qualifying events include the death of a Participant, divorce from a Participant, or a Dependent child ceasing to be eligible for coverage as a Dependent under the Plan. Participant must notify the Plan Administrator within **60 days** after the second qualifying event using the Notice Procedures previously stated. (Generally, this second qualifying event extension is not available under the Plan when a Participant becomes entitled to Medicare during the initial 18-month period of Continuation Coverage). **Failure to provide timely notice will result in non-extension of COBRA Continuation Coverage.**
- **Medicare or Other Group Health Coverage.**

  Note: Participant must notify the Plan Administrator if any Qualified Beneficiary has become entitled to Medicare and the date of Medicare entitlement.

  Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA Continuation Coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable preexisting condition exclusions of the other plan have been exhausted or satisfied).

  The rules set forth in Section 10 concerning coordination of benefits with Medicare apply for the period of Continuation Coverage only when a Qualified Beneficiary was also entitled to Medicare benefits on or before the date on which the Qualified Beneficiary elected COBRA.

- **Extension of COBRA Continuation Period for Disabled Participants.** The period of continuation shall be extended to 29 months (measured from the date of the qualifying event) in the event:
    - The Participant is disabled (as determined by the Social Security laws) within **60 days** after the date of the qualifying event; and
    - The individual provides evidence to the Plan Administrator or authorized representative of such Social Security Administration determination prior to the earlier of 60 days after the date of the Social Security Administration determination, or the expiration of the initial 18 months of COBRA Continuation Coverage.

      In such event, the Plan may charge the individual up to 150% of the amount of the group health plan cost for the COBRA coverage for all months after the 18th month of COBRA coverage, as long as the disabled Participant is in the covered group. The Participant must notify the Plan Administrator if a Participant is deemed no longer disabled, in which case COBRA Continuation Coverage ends as of the first day of the month that is more than **30 days** after the Social Security Administration determination.

      Notice Regarding Individual Policies. The Health Insurance Portability and Accountability Act ("HIPAA") requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a preexisting condition exclusion. To take advantage of this HIPAA right, Participant must elect Continuation Coverage under the Plan, and retain the coverage (by paying the required contribution) for the duration of Participant's 18, 29, or 36 month Continuation Coverage. Participant must then apply for coverage with an individual insurance carrier before Participant has a Significant Break in Coverage.

For general information regarding the Plan's COBRA coverage, Participant can contact Tim Klopfenstein at (540) 525-9693 or by mail at Virginia Private Colleges Benefits Consortium, Inc., 1 Cedar Hill Court, Suite D, Bedford, VA, 24523.

5.2 Michelle's Law

A covered Dependent will not lose his status as a covered Dependent while on a Medically Necessary Leave of Absence. A "Medically Necessary Leave of Absence" is a leave of absence from a post-secondary educational institution that:

- Commences while the Dependent is suffering from a severe Illness or Injury;
- Is Medically Necessary (as certified by the Dependent's Doctor); and
- Causes the Dependent to lose full time student status under the Plan.

Coverage may not terminate due to the Medically Necessary Leave of Absence until the earlier of:

- One year after the first day of the Medical Necessary Leave of Absence; or
- The date the coverage would otherwise terminate under the Plan.

(Section 5.2 may not be applicable due to the ACA's age 26 Dependent care mandate.)

5.3 USERRA Coverage

Participants Have Rights Under Both COBRA and USERRA. Participant's rights under COBRA and USERRA are similar but not identical. Any election that Participant makes pursuant to COBRA will also be an election under USERRA. COBRA and USERRA will both apply with respect to the Continuation Coverage elected. If COBRA or USERRA gives Covered Persons different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain Employees who are involved in the Uniformed Services. In addition to the rights that Participant has under COBRA, Participant is entitled under USERRA to continue the coverage Covered Persons had under the VPC Benefits Consortium.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty pursuant to orders issued under federal law, and the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of War or national Emergency.

Service in the Uniformed Services or Service means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain duty and training by intermittent disaster response personnel of the National Disaster Medical System.

- **Duration of USERRA Coverage.**
    - **General rule 24 months maximum**. When a Participant takes a leave for service in the Uniformed Services, USERRA coverage for the Participant (and Covered Dependents for whom coverage is elected) begin the day after the Participant (and Covered Dependents) lose coverage under the Plan, and it may continue for up to 24 months. However, USERRA coverage will end earlier if one of the following events takes place:
        - Participant fails to make a premium payment within the required time;
        - Participant fails to return to work within the time frame required under USERRA (see below) following the completion of Participant's service in the Uniformed Services; or
        - Participant loses rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.
    - **Returning to Work.** Participant's right to continue coverage under USERRA will end if Participant does not notify the Employer of the intent to return to work within the time frame required under USERRA following the completion of Participant's service in the Uniformed Services by either reporting to work (when absence was for less than 31 days) or applying for reemployment (if absence was for more than 30 days). The time for returning to work depends on the length of the absence, as follows:

Period of Absence	Return to Work Requirement
Less than 31 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 30 days but less than 181 days	Submit an application for employment not later than 14 days after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 180 days	Submit an application for employment not later than 90 days after the completion of the service.
Any period, if the absence was for purposes of an examination for fitness to perform service	Report to work at the beginning of the first regularly-scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
Any period if Participant was Hospitalized for or are convalescing from an Injury or Illness incurred or aggravated as a result of Participant's service	Apply for work or submit application as described above (depending on length of absence) when recovery is over, but recovery time is limited to two years. The 2 year period is extended by any minimum time required to accommodate circumstances beyond the Employee's control that make compliance with these deadlines unreasonable or impossible.

- **Concurrent.** COBRA coverage and USERRA coverage begin at the same time and run concurrently. However, COBRA coverage can continue longer, depending on the qualifying event, and is subject to different early termination provisions. In contrast, USERRA coverage can continue for up to 24 months, as described earlier in this Section.
- **Premium Payments for USERRA Continuation Coverage.** If Participant elects to continue health coverage pursuant to USERRA, the Participant will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if Participant's Uniformed Services leave of absence is less than 31 days, Participant is not required to pay more than the amount that Participant would pay as an active Employee for that coverage.

5.4 Family and Medical Leave Act

If a Participant is on a Family or Medical Leave of Absence, the Participant may continue coverage in accordance with the Family and Medical Leave Act of 1993 ("FMLA"), and the Plan will continue coverage, as if the Participant was Actively at Work as long as the following conditions are met:

- The required Contribution is paid; and
- The Participant has written approval of leave from the Member.

Coverage will be continued for up to the greater of:

- The leave period required by FMLA and any amendments thereto or regulations promulgated thereunder; or
- The leave period required by applicable state law.

If coverage is not continued during a Family or Medical Leave of Absence, when the former Participant returns to Actively at Work status and re-enrolls in the Plan, no new Waiting Period will apply.

Section 6
Prescription Drug Care

6.1 Preventive Care Medications

The Affordable Care Act requires the Plan to provide coverage for certain recommended preventive services and Preventive Care medications without the application of any Copayment, Deductible or Coinsurance. These Preventive Care services and medications will be covered by the Plan at 100%. All Preventive Care medications require a prescription from a licensed health care provider and must be obtained through the Plan's Prescription Drug card program to be covered at 100%.

The Plan may provide 100% coverage for certain additional medications. Coverage of these additional medications may vary by plan. Medications may be added or removed from the lists of covered medications at the sole discretion of the Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc. without prior notice to Covered Person.

Covered Persons may call Member Services at the number on the back of their ID card for additional information about these preventive services and medications. Covered Persons may also visit the federal government website for a complete list of Affordable Care Act required preventive services and medications.

The website is found at: https://www.healthcare.gov/preventive-care-benefits/

6.2 Preventive Rx Drugs

Preventive Rx drugs are selected drugs used in the management of Asthma, Diabetes, Hypertension, and Hyperlipidemia. These drugs are covered at no charge to Covered Persons.

Medications are under continual review, and may be added to or removed from the list of Preventive Rx drugs at the sole discretion of the Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc. at any time without prior notice to Covered Persons. Therefore, please access the current list of Preventive Rx drugs by calling, toll-free, 833-389-1968. .

6.3 Retail Prescription Program

To receive drug benefits under the Plan, a Covered Person can purchase Prescription Drugs from a pharmacy in amounts up to a 90-day supply as further described in the associated SBCs.

If You are going on vacation and You need more than the day supply allowed, You should ask Your pharmacy to call its pharmacy benefits manager ("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 ID card.

6.4 Mail Service Prescription Program

A Covered Person can order long-term Maintenance Prescription Drugs by mail order in amounts up to a 90-day supply as further described in the associated SBCs.

Notice: This Plan uses one or more drug formulary (i.e. a list of drugs for which coverage is provided or Doctors are encouraged or offered incentives to provide.) The presence of a drug on the Plan's list does not guarantee a Doctor will prescribe it.

6.5 Limitations and Exclusions

This section refers only to Prescription Drugs. A complete list of all medical services excluded under this Plan is provided in Section 8.

The following Prescription Drugs are limited or excluded from the Prescription Drug Card Program:

- Drugs used for artificial methods of conception;
- Cosmetic indications and anti-wrinkle agents (e.g. Renova) for individuals 35 years or older;
- Dermatologicals and hair growth stimulants (e.g. Rogaine);
- Drugs covered under Workers Compensation, Medicare or Medicaid;
- Growth hormones, unless Preauthorized;
- Fertility/infertility medications;
- Injectibles (Insulin and other injectibles specifically approved by the Plan are Covered Services and not subject to this exclusion);
- Non-legend drugs other than those specifically listed (a non-legend drug is one for which no prescription is required by state or federal law);
- Prescription Drugs or medications used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmia, and decreased libido (e.g. Viagra), except where such sexual dysfunction is caused by surgery (e.g. prostate surgery), are limited to 6 tablets per month;
- Smoking deterrent medications are covered for over the counter and prescriptions drugs for smoking cessation;
- Vitamins or minerals, singly or in combination. Exception: Legend prenatal vitamins are covered for pregnancy;
- Therapeutic devices or appliances, including support garments, respiratory chambers (e.g. Aerochamber), ostomy supplies, and other non-medicinal substances;
- Charges for administration or injection of any drug;
- Drugs labeled, “Caution-limited by federal law to investigational use,” or Experimental Procedures, even though a charge is made to the individual;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, Ambulatory Care Facility, Extended Care Facility, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Other Facility Provider, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals; and
- Over-the-counter drugs.

Cancer Prescription: Coverage may not be excluded for any prescription drug approved by the Food and Drug Administration that has been proven effective and is acceptable to treat the specific type of cancer for which the prescription drug has been prescribed by either: (1) the American Medical Association Drug Evaluations; (2) the American Hospital Formulary Service Drug Information; or (3) the United States Pharmacopoeia Drug Information.

Any drug listed by brand name in this Section shall include its generic equivalent when available.

6.6 Financial Credits

Financial credits from drug manufacturers based on the total volume of claims processed for their products utilized by Participants are used to reduce Plan costs and fees for administering the program. Reimbursements to pharmacies are not affected by these credits.

6.7 Tier 4 Drugs

Participants who use certain covered Tier 4 (formerly "specialty") drugs must purchase them through the specialty pharmacy Network of their pharmacy claims processor. Information about the Plan's specialty pharmacy, may be obtained by contacting the pharmacy claims processor, CarelonRx, at 833-389-1968.

Tier 4 drugs will be covered only when obtained through the specialty pharmacy network. Tier 4 drugs are 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.

6.8 Automated Accumulator Prescription Drug Program

For certain Prescription Drugs, manufacturer copays, coupons or other manufacturer cost sharing assistance payments, whether made directly or indirectly, do not apply to the satisfaction of Your Deductible or to Your Out-of-Pocket Maximum. Contact CarelonRx Customer Service at 833-389-1968 if You have questions or need more information about this program.

6.9 Variable Copay Prescription Drug Program

Copays for certain Prescription Drugs may be set higher than the standard Copayment in order to benefit from the Copayment assistance provided by manufacturer programs designed to help You reduce Your pharmacy costs. Your actual Copayment will be adjusted to be no higher than Your standard copayment so that Your actual Out-of-Pocket cost will remain the same or lower. The Variable Copay Prescription Drug Program will activate on a post-deductible basis for High Deductible Health Plan Participants.

Section 7
Covered Services

7.1 Comprehensive Major Medical Expense Benefit

The Comprehensive Major Medical Expense Benefit provides coverage for a wide range of services called Covered Services. The services associated with this benefit are covered to the extent that they are:

- Medically Necessary;
- Prescribed by or given by a Doctor;
- Allowable Charges; and
- Provided for care and treatment of a covered Illness or Injury.

Benefits are payable in accordance with the applicable Deductible amounts and benefit percentages listed in the associated SBCs, unless otherwise listed as a Covered Expense.

7.2 Preventive Care

The plan covers Preventive Care services for children, adolescents and adults.

Preventive Care services generally include check-up visits, developmental assessment and guidance, screening tests, intervention counseling/education services, immunizations and other services to prevent the development of disease, or allow the detection of medical conditions in advance.

Services are covered as Preventive Care for children, adolescents and adults with no current symptoms or prior history of the medical condition associated with the screening or service. Participants who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition, but instead benefits will be considered under the diagnostic services benefit.

Additionally, a routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and the provider performs additional necessary Covered Services, these services will generally be covered as diagnostic and/or surgical services and not as Preventive Care services. Deductibles, Copayments and Coinsurance amounts applicable to diagnostic and/or surgical services may be different from those applicable to Preventive Care services; for more information, please see the attached Schedule which provides a summary of the Covered Expenses, Limitations and Exclusions that apply to the Plan.

The Preventive Care services in this section meet the requirements outlined under federal and state law.

These Preventive Care services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;
    - Type 2 diabetes mellitus;
    - Cholesterol;

- Child and adult obesity, including counseling services related to nutrition;
- Certain over-the-counter (OTC) items and services when prescribed by a health care provider, including aspirin, folic acid supplement, vitamin D supplement, iron supplement, and bowel preparations. Age and gender and quantity limitations apply; and
- Tobacco-cessation counseling, Prescription Drugs, and nicotine replacement therapy products when prescribed by a provider, including over-the-counter (OTC) nicotine gum, lozenges and patches for Participants age 18 and older. Tobacco cessation Prescription Drugs and OTC items are limited to a no more than a 180-day supply per 365 days.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive Care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. The health plan covers additional Preventive Care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Women's contraceptives including all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and counseling. Contraceptive coverage includes generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Standard multi-source Brand Drugs will be covered as a Preventive Care benefit when medically necessary, otherwise, they will be covered under the prescription drug benefit.
    - Breastfeeding support, supplies, and counseling. Standard benefits for breast pumps are limited to one pump per pregnancy.
    - Gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
    - Testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of pap smear results.
    - Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.
    - Screening and counseling for interpersonal and domestic violence.
    - Well woman visits.
    - Breast Cancer Susceptibility Gene (BRCA) screening, counseling, and genetic testing for women at higher risk.

Participants may obtain additional information about these Preventive Care services by contacting Member Services. Participants may also visit the federal government websites:

- https://www.healthcare.gov/coverage/preventive-care-benefits/;
- https://www.ahrq.gov; or
- http://www.cdc.gov/vaccines/acip/index.html

The Plan also covers the following as required by state law:

- Routine screening mammograms.
- Annual Pap smear for testing performed by any FDA-approved gynecologic cytology screening technologies.
- Annual prostate cancer screenings and digital rectal exam, including PSA test for males who are at least 50 years old or at least 40 years old who are at high risk for prostate cancer.

7.3 Covered Services

Covered Services are the services listed below, subject to the Limitations and Exclusions below, and all other provisions of this Plan:

- **Allergy Services.** Allergy testing, treatment, serum and injections will be payable as shown in the associated SBCs.
- **Ambulance Service.** Hospital or 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 we require You to move from an Out-of-Network Hospital to an In-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 we require You to move from an Out-of-Network Hospital to an In-Network Hospital
    - Between a Hospital and an approved Facility.

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

  Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If You do not use the air ambulance Provider we select, 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 we may approve benefits for transportation to a Facility that is not the nearest Facility.

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

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

Other non-covered ambulance services include, but are not limited to, trips to:

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

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

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

Air Ambulance 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.

Note: Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.

- **Ambulatory Surgical Facility.** Services and supplies furnished by an Ambulatory Surgical Facility.
- **Anesthetics.** Anesthetics and their professional administration.
- **Attention Deficit Disorders.** Treatment and prescription medication as deemed Medically Necessary for attention deficit disorders and behavioral disorders as shown in the associated SBCs for Mental Health Conditions.
- **Autism Services.** Certain treatment associated with autism spectrum disorder (ASD). Coverage for ASD includes but is not limited to the following:
  - Diagnosis of autism spectrum disorder;
  - Behavioral Health Treatment of autism spectrum disorder;
  - Pharmacy care;
  - Psychiatric care;
  - Psychological care; and
  - Therapeutic care.

  Treatment for ASD includes Applied Behavioral Analysis when provided or supervised by a board certified behavior analyst, licensed by the Board of Medicine, and billed by such behavior analyst, and the prescribing practitioner is independent of the provider of the Applied Behavioral Analysis.

- **Blood Plasma.** Services and supplies required for the administration of blood transfusions, including blood, blood plasma, and plasma expanders, when not available to the Covered Person without charge.
- **Breast Reduction Surgery.** Breast Reduction Surgery when Medically Necessary and not solely for Cosmetic or Reconstructive purposes.
- **Cervical Cancer Screening.** Cervical cancer screening will be covered as listed in the associated SBCs. Covered procedures include: pap smear screening, liquid based cytology and Human Papilloma Virus ("HPV") detection methods for covered females with equivocal findings on cervical cytologic analysis that have been approved by the United States Food and Drug Administration.
- **Chiropractic Treatment.** See Spinal Manipulation Treatment.
- **Clinical Trials**

  Benefits:

  Benefits include coverage for services 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:

  - Federally funded trials approved or funded by one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - Cooperative group or center of any of the four (4) entities listed immediately above or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - Any of the following Departments listed in this subpart below if the study or investigation has been reviewed and approved through a system of peer review that the U.S. 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.
      - The Department of Veterans Affairs.
      - The Department of Defense.
      - The Department of Energy.
  - Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

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

You may be required to use an In-Network provider to maximize Your benefits. You must call Member Services to find out.

When a requested service is part of an approved clinical trial, it is a covered service even though it might otherwise be investigational as defined by this plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our clinical coverage guidelines, related policies and procedures.

Exclusions:

The plan may not provide the benefits listed immediately below and reserves the right to exclude any of the following:

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

- **Cleft Lip and Related Conditions.** Inpatient and Outpatient dental, oral surgical, and orthodontic services which are Medically Necessary for the treatment of cleft lip, cleft palate or ectodermal dysplasia.
- **Colorectal Cancer Screening.** Colorectal Cancer Screening will be covered as any other Illness. Covered procedures include: medically recognized screening, specialty screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, shall be provided in accordance with the most recently published recommendation established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, Family histories, and frequencies referenced in such recommendation.
- **Contact Lenses After Cataract Surgery.** Initial purchase of contact lenses and/or eyeglasses if required as a result of cataract surgery.
- **Contraceptives.** Any prescribed Drug or device approved by the United States Food and Drug Administration for use as a contraceptive. Oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods are covered.
- **Cosmetic or Reconstructive Surgery.** Cosmetic or Reconstructive Surgery, if such surgery is to restore bodily function or correct deformity resulting from an Illness or Injury covered under this Plan.
- **Craniofacial Abnormalities.** For children younger than 18 years of age, reconstructive surgery for craniofacial abnormalities, meaning surgery to improve function of, or attempt to create a normal appearance of an abnormal structure caused by Congenital Defects, development deformities, trauma, tumors, infections or disorder.
- **Dental Care.** Medical expenses for Dental Care shall include coverage for Medically Necessary general anesthesia and Hospitalization or charges for an Ambulatory Care Facility licensed to provide Outpatient surgical procedures for dental care to a Covered Person who is determined by

a licensed Dental provider, in consultation with the Covered Person's treating Doctor to require general anesthesia and admission to a Hospital or Ambulatory Care Facility to effectively and safely provide dental care if such Covered Person is:

- Is under the age of 5 years old;
- Is severely disabled; or
- Has a medical condition and requires admission to a Hospital or Ambulatory Care Facility and general anesthesia for dental care treatment
- The Plan shall always pay secondary to any other dental coverage. No other expenses for dental work are included as a Covered Expense.

- **Diabetic Supplies and Education.** Benefits for equipment, supplies (for diabetic coverage, equipment and supplies are not considered Durable Medical Equipment) and in-person Outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-Dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

  Diabetes in-person Outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

- **Diagnostic Charges and Preadmission Testing.** X-ray, laboratory services, diagnostic charges and preadmission testing.

- **Dietitians.** Services of a licensed dietitian within the scope of licensure if related to Injury or Illness covered by the Plan and if recommended by a Doctor in connection with an examination or treatment covered by the Plan.

- **Doctor's Services.** Doctor's fees for medical and surgical services as well as services of an assistant surgeon when required, as limited by Section 3, and other Medically Necessary services.

  Services performed in a Doctor's office on the same day or following business day for the same or related diagnosis, whether a Doctor is seen or not, will be payable as shown in the associated SBCs. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, allergy shots, cast application and minor Surgery. If more than one Doctor is seen in the same clinic on the same date, only one Copayment will apply.

- **Durable Medical Equipment.** Coverage for the rental (or purchase if that would be less expensive) of Durable Medical Equipment when obtained from a PPO Durable Medical Equipment provider. Also covered are maintenance and necessary repairs of Durable Medical Equipment except when damage is due to neglect.

  Examples of covered Durable Medical Equipment include:

  - Nebulizers;
  - Hospital type beds;
  - Wheelchairs;
  - Traction equipment;

- Walker; and
- Crutches.

- **Early Intervention Services.** Your coverage includes benefits for early intervention services for covered Dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of:
  - speech and language therapy;
  - occupational therapy;
  - physical therapy; and
  - assistive technology services and devices.

  Early intervention services for the population certified by the Department are those services listed above which are determined to be Medically Necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without affecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not medically necessary.
- **Emergency Services.** Emergency Services means, with respect to an Emergency Medical Condition:
  - A medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
  - Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under section 1867 of such Act to Stabilize the patient.
- An Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.
- **Gynecological or Obstetric Care.** A female Participant or Dependent may select, in addition to a Primary Care Physician, a properly credentialed obstetrician, gynecologist, Family Doctor, internist, or other qualified Doctor (without referral) for obstetric and/or gynecological care. Covered Services include one well-women examination per year, care related to pregnancy, and diagnosis treatment and referral for any obstetric or gynecological disease or condition, including Inpatient Care as Medically Necessary.
- **Hearing Screening.** Coverage for infant hearing screenings and all necessary audiological examinations using any technology approved by the United States Food and Drug Administration, and as recognized by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Coverage shall include follow-up audiological examinations as recommended by a Doctor or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

- **Hemophilia and Other Congenital Bleeding Disorders.** Coverage for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Coverage includes purchase of blood products and blood infusion equipment required for home treatment when the home treatment program is under the supervision of a state-approved hemophilia treatment center.
- **HIV/AIDS.** Injuries or Illnesses as a result of HIV/AIDS will be a Covered Expense.
- **Home Health Care.** Services of a Home Health Care Agency, at the percentage shown in the associated SBCs, for services furnished to a Covered Person in the home in accordance with a Home Health Care plan.

  The Home Health Care plan must be established and approved by the Doctor and must certify that a Hospital confinement would otherwise be required.

  Covered Services include:

  - Part time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.), if Medically Necessary;
  - Part time or intermittent Home Health aide services performing services specifically ordered by a Doctor;
  - Occupational therapy, speech therapy, physical therapy and respiratory therapy provided by a Home Health Care Agency; and
  - Medical supplies, medicines, and equipment prescribed by a Doctor and provided by the Home Health Care Agency if such items would have been covered while Hospital confined.

  For determining the limit of benefits with respect to services set forth in items listed above, each visit by a member of a Home Health Care Agency shall be considered as one Home Health Care visit and 4 hours of Home Health aide services shall be considered as one Home Health Care visit.

  In addition to the Limitations and Exclusions below, benefits will NOT be provided for any of the following:

  - Services of a person who ordinarily resides in a Covered Person's home or is a member of the Covered Person's Family or spouse's Family;
  - Custodial Care, consisting of services and supplies which are provided to an individual primarily to assist in the Activities of Daily Living;
  - Any period during which the Covered Person is not under the continuing care of a Doctor;
  - Homemaker or housekeeping services except by Home Health aides as ordered in the Home Health Care treatment plan;
  - Supportive environmental materials such as handrails, ramps, air conditioners and telephones;
  - Services performed by volunteer workers;
  - Social services and dietary assistance;
  - Separate charges for records, reports or transportation;
  - Expenses for the normal necessities of living, such as food, clothing, and household supplies;
  - Services rendered or supplies furnished to anyone other than the Covered Person;

- Any services or supplies not included in the Home Health Care treatment plan or not specifically set forth as a Covered Expense; and
- Services provided during any period of time in which the Covered Person is receiving benefits under this Plan's Hospice Care benefit.

- **Hospice Care.** Hospice Care on either an Inpatient or Outpatient basis as an alternative to Hospitalization for Terminally Ill person, as shown in the associated SBCs.

  Covered Services must be rendered, furnished and billed by a Hospice and included in a written Hospice treatment plan established and periodically reviewed by a Doctor. The Hospice treatment plan must:

  - Certify that the Covered Person is Terminally Ill and has less than a 6 month life expectancy;
  - Certify that it is medically advisable for the Covered Person to live at home;
  - Certify that Hospital confinement would be required in the absence of Hospice Care; or
  - Describe the services and supplies for the palliative care and Medically Necessary treatment to be provided to the Covered Person by the Hospice.

  Covered Services include:

  - An assessment visit and initial testing;
  - Room and board, services and supplies furnished by a Hospice while confined therein;
  - Patient care provided by Home Health aides;
  - Visits by speech therapists and psychotherapists;
  - Intermittent care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
  - Drugs and medicines for the Terminal Illness that are legally obtainable only upon a Doctor's written prescription and insulin while receiving Hospice Care on an Inpatient basis only;
  - Medical supplies normally used for Hospital Inpatients, such as oxygen, catheters, needles, syringes, dressing, materials used in aseptic techniques, irrigation solutions, intravenous solutions and other medical supplies including splints, trusses, braces or crutches;
  - Rental of Durable Medical Equipment;
  - Family counseling of immediate Family members;
  - Respite care;
  - Professional medical, psychological, psychosocial and pastoral counseling services utilizing a medically directed interdisciplinary team; and
  - Supportive services to the bereaved immediate Family members for up to 3 months following the death of the Covered Person.

  In addition to the Limitations and Exclusions below, benefits will NOT be provided for any of the following:

  - Homemaker or housekeeping services except by Home Health aides as ordered in the Hospice treatment plan;
  - Supportive environmental materials such as handrails, ramps, air conditioners and telephones;

- Services performed by Family members or volunteer workers;
- "Meals on Wheels" or similar food services;
- Separate charges for records, reports or transportation;
- Expenses for the normal necessities of living, such as food, clothing and household supplies;
- Services rendered or supplies furnished to other than the Terminally Ill Covered Person except as listed above;
- Any services or supplies not included in the Hospice treatment plan or not specifically set forth as a Covered Expense;
- Legal and financial counseling services; and
- Services provided during any period of time in which the Covered Person is receiving benefits under this Plan's Home Health Care benefit.

- **Hospital Services**.
  - **Inpatient.** Hospital room and board, general nursing care, and regular daily services to the extent of the room and board allowance shown in the associated SBCs.

    Note: For treatment in an Out-of-Network Hospital, if a private room is used, the most frequent semi-private room rate will be used unless confinement in a private room is specifically requested by the Doctor due to the nature of the Illness and/or Injury. An explanation must be submitted to the Claims Administrator.

    Intensive Care Unit or other special care unit such as Coronary Care, up to the amount specified in the associated SBCs (but not for the concurrent use of any other Hospital room).

    Medically Necessary services and supplies furnished by the Hospital while confined as an Inpatient.

    Coverage is not extended for a Hospital when the services could be rendered by an Other Facility Provider at a lesser expense.
  - **Outpatient.** Medically Necessary services and supplies furnished by a Hospital while being treated on an Outpatient basis such as:
    - Allergy testing;
    - Chemotherapy;
    - Dialysis;
    - Emergency Room Services (subject to the associated SBCs);
    - Laboratory tests and X-rays;
    - Preadmission testing;
    - Radiation therapy;
    - Respiratory therapy; and
    - Surgical services.
- **Hysterectomy.** Medical expenses for laparoscopy–assisted vaginal hysterectomy and vaginal hysterectomy when Medically Necessary. Includes a minimum Hospital stay of 23 hours for laparoscopic hysterectomy and 48 hours for vaginal hysterectomy. Minimum hours are not

required if attending Doctor, in consultation with Covered Person, determines a shorter period of Hospital stay is appropriate.

- **Immunization.** Immunization against diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, and any other immunization as may be prescribed by the Commissioner of Health. No Deductibles apply.
- **Lymphedema.** Coverage for equipment, supplies, complex decongestive therapy, and Outpatient self-management training and education for the treatment of lymphedema if lawfully prescribed by a Doctor.
- **Mammography.** Coverage for one mammogram annually for Covered Persons over the age of 35. Coverage to include digital mammograms. Further mammograms may be covered if the Covered Person has a history of breast cancer and such additional mammogram is Preauthorized.
- **Mastectomy or related procedure.** Expenses incurred with respect to a mastectomy or lymph node dissection in connection with breast cancer. For a mastectomy, the Plan will cover a minimum 48 hour Hospital stay. For lymph node dissection, the Plan will cover a 24 hour Hospital stay
- **Maternity Expenses.** Expenses incurred by either Participant or Covered Dependents as shown in the associated SBCs, for:
    - Pregnancy to include prenatal care, services provided by a Birthing Center, one amniocentesis test per pregnancy, and up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary);
    - Midwife Services when Midwife is licensed in the state where services are rendered; and
    - Complications of Pregnancy.
    - For an uncomplicated vaginal delivery, this Plan will cover a 48 hour Hospital stay. For an uncomplicated cesarean delivery, the Plan will cover a 96-hour Hospital stay. If a decision is made to discharge a mother or newborn before the expiration of the minimum hours, listed above, coverage is provided for timely post-delivery care by a Doctor, Midwife, Registered Nurse, or other appropriate licensed health care provider and may be provided at the mother's home, a health care provider's office, or a Health Care Facility.
- **Medical Devices and Appliances**. Coverage for the cost of fitting, adjustment, and repair of the following items when prescribed for Activities of Daily Living:

  Examples of covered medical devices include:
    - Orthopedic braces;
    - Leg braces, including attached or built-up shoes attached to the leg brace;
    - Molded, therapeutic shoes for diabetics with peripheral vascular disease;
    - Arm braces, back braces, and neck braces;
    - Head halters;
    - Catheters and related supplies;
    - Orthotics, other than foot orthotics; and
    - Splints.

- **Medical Records.** Expense for obtaining Medical records will be paid in full to a Maximum Benefit of $50 per provider.
- **Mental Health Conditions or Substance Use Disorders.** Covered Services for the diagnosis and treatment of a Mental Health Conditions and Substance Use Disorders.
    - **Inpatient Treatment.** Inpatient Care for Mental Health Conditions and Substance Use Disorders. Coverage includes individual psychotherapy, psychological testing, counseling with Family members to assist with the patient's diagnosis and treatment, and convulsive therapy treatment. Inpatient services for Substance Use Disorder must be provided in a Hospital or Substance Use Treatment facility which is licensed to provide a continuous, structured, 24 hour a day program of drug or alcohol treatment and rehabilitation including 24 hour a day nursing care. Coverage includes residential treatment.
    - **Partial Day Mental Health Conditions and Substance Use Disorder Programs.** A partial day program must be licensed or approved by the state and must include day or evening treatment programs which lasts at least 6 or more continuous hours per day for Mental Health Conditions and Substance Use Disorders, or an intensive Outpatient program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence.
    - **Outpatient**. Outpatient Care for treatment of Mental Health Conditions and/or complications thereof, up to the maximum shown in the associated SBCs, provided services are rendered by:
        - A licensed Hospital;
        - Psychiatric Hospital;
        - Outpatient psychiatric center;
        - A community mental health center;
        - A Doctor;
        - Psychologist;
        - Licensed professional counselor; or
        - Clinical social worker (upon referral by a Doctor) holding a license for such services and acting in accordance with that license.
    - **Outpatient Treatment.** Includes treatment for Outpatient Mental Health Conditions and Substance Use Disorders.
    - **Medication Management.** Visits with a Doctor to ensure the medication taken for a Mental Health Conditions and Substance Use Disorders problem is working and the dosage is correct is a Covered Expense.

      Coverage for Mental Health Conditions and Substance Use Disorders shall be neither different nor separate from coverage for any other Illness for the purpose of determining Deductibles, Benefit Year or Lifetime discretional limits, Benefit Year or Lifetime Maximum Benefits, episode or treatment limits, Copayments, and Coinsurances.
- **Newborn Expenses.** Newborn Expenses for the following shall be paid under the Newborn's own claim:
    - Hospital nursery expenses;
    - Pediatric care;

- Circumcision;
- Hearing Exams as described above;
- Cleft Lip and related conditions as described above; and
- Congenital Defects and birth abnormalities.

> ***Note:*** Newborn coverage shall include coverage for Injury or Illness, including the necessary care or treatment of medically diagnosed congential defects, birth abnormalities or prematurity. Covered Services included transportation costs of the newborn to and from the nearest Hospital or other Urgent Care Facility appropriately staffed and equipped to treat the newborn's condition. The transportation must be Medically Necessary to protect the health and safety of the newborn as certified by the attending Doctor.

> ***Note:*** From the moment of delivery, each newborn is subject to a separate Deductible and Copayments as set forth in the associated SBCs.

- **Nursing Services.** Nursing care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) prescribed by a Doctor.
- **Nutritional Counseling.** Coverage for eating disorders. Coverage will be limited to medical providers and will not include coverage for traditional weight loss plans such as Weight Watchers, Jenny Craig, etc. Coverage will also not include access to personal trainers, gym facilities, etc.
- **Obesity.** Coverage of certain treatments for Morbid Obesity including selected surgical procedures recognized by the National Institutes of Health (NIH). To qualify, Covered Persons must be age 18 or older and have a body mass index (BMI) of 40.0 or greater, where BMI equals weight in kilograms divided by height in meters squared. Coverage does not include weight loss medications or weight control dietary supplements. Precertification is required. A separate copay which does not apply to or count toward the Out-of-Pocket Maximum applies. The procedure must be performed at an identified Bariatric Surgery center of excellence in the Network.

> **Coverage is not available Out-of-Network and is not available under Plan 6, Plan 6N, Plan 7, Plan 7N, or under Plan 12. More complete information, including the VPC Benefits Consortium Bariatric Surgery Policy, is available from the Plan Administrator.**

- **Occupational Therapy.** Occupational therapy rendered by a licensed Occupational Therapist or Certified Occupational Therapist Assistant (C.O.T.A.). This care must be prescribed by a Doctor.
- **Oral Surgery.** Medical expense for oral surgery include:
  - When necessitated as the direct result of an Injury to natural teeth or dental prosthesis if treatment begins within 6 months of the date of the Injury (chewing related expenses not covered);
  - For the surgical removal of impacted wisdom teeth;
  - Care of fractures or complete dislocation of the jaw;
  - Alveolectomy when related to tooth extraction;
  - Maxillary or mandibular frenectomy when not related to a dental procedure;

- Surgical services on the hard or soft tissues in the mouth when the main purpose is not to treat or help the teeth and their supporting structures;
- The treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Surgical removal of tumors within the oral cavity; or
- For Dependents age 8 or less, general anesthesia and Hospital expenses for covered dental care when there is a serious underlying medical condition which exists or where necessary due to accidental Injury to sound natural teeth. (Preauthorization required.)

  For the purpose of the oral surgery covered by the terms of this benefit, Covered Services shall be deemed to include fees of a duly licensed Dentist. The Plan shall always pay secondary to any other dental coverage.

- **Orthognathic Surgery.**
  - **Medically Necessary**. Orthognathic surgery is considered Medically Necessary to treat a medical condition or Injury which prevents normal function of the joint or bone when the procedure can be reasonably expected to attain functional capacity of the affected part. A medical condition or Injury which prevents normal function of the joint or bone includes any of the following:
    - Choking, difficulty swallowing or ability to chew only soft or liquid food;
    - Symptoms must be documented in the medical record, must be significant and must persist for at least 4 months;
    - Other causes of swallowing/choking problems have been ruled out by history, physical exam or appropriate diagnostic studies including but not limited to, allergies, neurologic or metabolic disease or hypothyroidism; or
    - Speech abnormalities determined by a speech pathologist or therapist to be due to a malocclusion and not helped by orthodontia or at least six months of speech therapy; or
    - Intra-oral trauma while chewing related to malocclusion (e.g. loss of food through the lips during mastication, causing recurrent damage to the soft tissues of the mouth during mastication); or
    - Masticatory Dysfunction/Malocclusion as defined in the Glossary.
  - **Reconstructive.** Orthognathic surgery is considered reconstructive when a significant physical functional impairment is not present, but when there is a significant variation in the normal anatomy of the maxilla and mandible.
  - **Cosmetic and Not Medically Necessary.** Procedures intended to change a physical appearance that would be considered within normal human anatomic variation are considered cosmetic and not Medically Necessary.

    A genioplasty (or anterior mandibular osteotomy) not associated with masticatory malocclusion is considered cosmetic and not Medically Necessary.

    This Plan does not cover orthodontia (braces) services.

- **Ostomy Supplies.** Ostomy Supplies are a Covered Expense under the Plan.
- **Ovarian Cancer Screening.** Transvaginal ultrasound and rectovaginal pelvic examination are covered for females age 25 and older who are at risk of ovarian cancer.

- **Oxygen.** Medically Necessary oxygen and rental of equipment for its administration.
- **Pain Management.** Access to a pain management Specialist and coverage for treatment of pain, as recommended by a pain management Specialist for all Medically Necessary medications and procedures required to diagnose and develop a pain treatment plan.
- **Pap Smear.** Expenses incurred for laboratory charges for pap smears for annual testing by any FDA-approved gynecologic cytology screening technologies, as shown in the associated SBCs.
- **Pediatric Exams.** Periodic examination by a Doctor at approximately the following ages: Birth, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, and once a year until age 18.
- **Postpartum Services.** Postpartum services including, Inpatient and Home Health Care visit or visits in accordance with Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists including any changes to such Guidelines or Standard within 6 months of publication or any official amendment thereof.
- **Physical Therapy.** Physical Therapy rendered by a licensed Physical Therapist or Physical Therapist Assistant (P.T.A.) prescribed by a Doctor in an office setting.
- **Prescription Drugs.** FDA approved Prescription Drugs and medicines for the treatment of an Illness or Injury, required by law to be prescribed in writing by a Doctor and dispensed by a licensed pharmacist are covered by the Prescription Drug Card Program. Only Doctor-dispensed Prescription Drugs are Covered Services under the health Plan.
- **Private Duty Nursing.** Private Duty Nursing services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) prescribed by a Doctor.
- **Prostate Cancer Screening.** Annual medically recognized diagnostic examination for the detection of prostate cancer, including:
    - Digital rectal examination;
    - A physical examination for the detection of prostate cancer; and
    - A prostate-specific antigen test for each male enrolled in the Plan who is:
        - At least 50 years of age; or
        - At least 40 years of age who is at high risk for prostate cancer.
- **Prosthetics.** Artificial limbs and eyes when Medically Necessary for Activities of Daily Living as the result of an Illness or Injury, including repair, maintenance and replacement when Medically Necessary.
    - **Hearing Aids.** Coverage for Medically Necessary hearing aids of up to $2,500.00 per ear every thirty-six (36) months. This includes bone-anchored hearing aids and Medically Necessary services to assess, select, adjust, or fit the hearing aid. Covered Services may be obtained from a licensed audiologist or a licensed hearing instrument specialist. Coverage does not include over-the-counter hearing aids. Some items and services may require preauthorization.
- **Radiation Therapy and Chemotherapy.** X-ray, radium, radioactive isotope therapy, and chemotherapy. Includes, for the treatment of breast cancer, dose-intensive chemotherapy/ autologous bone marrow transplants or stem cell transplants.

- **Rape or Incest.** Charges associated with Injuries or Illnesses as a result of a Rape or Incest.
- **Reconstructive Surgery Following Mastectomy.** Breast implants and reconstructive surgery as well as complication of implants and reconstructive are covered as follows:
  - All stages of reconstruction of the breast on which a mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prosthesis and treatment of physical complications including lymphedemas; and
  - External breast prostheses and bras.
- **Respiratory Therapy.** Medically Necessary respiratory therapy when prescribed by a Doctor.
- **Scalp Hair Prosthesis.** See Wigs.
- **Self-Inflicted Injury.** Costs arising from a Self-Inflicted Injury are a Covered Expense.
- **Skilled Nursing Facility/Extended Care Facility/Rehabilitation Facility.** Confinement in a Skilled Nursing Facility, provided:
  - Such confinement begins within 5 days following an eligible Hospital confinement;
  - Such confinement is under the supervision of a Doctor;
  - The attending Doctor certifies 24 hour nursing care is necessary for recuperation from the Injury or Illness which required Hospital confinement; and
  - Such confinement is for necessary recuperative care of the same condition requiring the prior Hospitalization.

  The total of all Medically Necessary services and supplies (including room and board) furnished by the facility cannot exceed the maximum shown in the associated SBCs.
- **Speech Therapy.** Speech therapy provided by a speech therapist in an office setting if any of the following conditions are met:
  - The service of a speech therapist is required to restore a speech Disability that the patient lost as a direct result of an Illness or Injury; and
  - The services of the therapist are prescribed by a Doctor who continues to control and direct the overall treatment of the case, as Medically Necessary to improve the specific defect; or
  - The Covered Person is under the age of 16 and speech therapy is for developmental delay.
- **Spinal Manipulation Treatment.** The detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference which is the result of or related to distortion, misalignment, or subluxation of or in the vertebrae column (such treatment is limited as shown in the associated SBCs).
- **Sterilization.** Elective Sterilization regardless of Medical Necessity.
- **Substance Use Treatment.** See Mental Health Conditions or Substance Use Disorders.
- **Surgery.** When more than one surgical procedure is performed during the same operation, the Allowable Charge for all of the services combined will be calculated by adding:
  - The Allowable Charge for the service with the highest Allowable Charge; plus
  - A reduced percentage of what the Allowable Charge would have been for each of the additional surgical services if these services had been performed alone.

- See Section 3 for additional information on Allowable Charges for Surgical Services.

- **Telemedicine.** A Telemedicine medical service or a telehealth service will not be excluded from coverage solely because the service is not provided through a face to face consultation.

- **Transplants, Organ and Tissue.** Medically Necessary human organ and tissue transplants, as well as certain cellular and gene therapies, are covered under the Plan. Covered Transplants and Cellular/Gene Therapies include:

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

  Services must be performed by an Approved In-Network Transplant and Cellular/Gene Therapy Provider to be covered at the In-Network level. Approved In-Network Transplant and Cellular/Gene Therapy Providers include the following:

  - **Blue Distinction Center Facility**: Blue distinction facilities have met or exceeded national quality standards for care delivery of Covered Transplants and Cellular/Gene Therapies.
  - **Centers of Medical Excellence Facility**: Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery of Covered Transplants and Cellular/Gene Therapies.

  Providers that are NOT considered an Approved In-Network Transplant and Cellular/Gene Therapy Provider include:

  - In-Network Providers who participate in the Plan's networks, but who are not an Approved In-Network Transplant and Cellular/Gene Therapy Provider; and
  - Out-of-Network Providers.

  Prior Approval and Precertification. Participants (or the Participant's Provider) must contact the Transplant Department for precertification by calling 888-574-7215 prior to obtaining Covered Transplants and/or Cellular/Gene Therapy. Failure to obtain precertification will result in a denial.

  Medically Necessary. Certain organ or tissue transplants are considered experimental/ investigative or not Medically Necessary.

  - Autologous bone marrow transplants for breast cancer are covered despite the exclusion in the Plan for experimental/ investigative services.

  Donor Benefits. When a human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive the benefits of the Plan.

  Transportation and Lodging. Reasonable and necessary travel costs of approved services and procedures will be covered when travel more than 75 miles from the Participant's permanent home is required to reach the facility where the approved service or procedure will be performed. Travel costs include transportation to and from the facility and lodging for the Participant and one companion (unless the Participant is a minor, then two companions are permitted). Travel costs

will be covered on a per transplant/therapy basis. Itemized receipts will be required as part of the claim submission and approval process.

- **Transportation by Railroad or Scheduled Commercial Airline.** Transportation by railroad or scheduled commercial airline to, but not from, a Hospital equipped to furnish special treatment approved and recognized by the American Medical Association for the Injury or Illness (excluding any transportation from or to points outside the continental limits of the United States or Canada), if approved by the Preauthorization provider.
- **Vision Exams.** Vision Exams as listed in the associated SBCs.
- **Wigs or Scalp Hair Prosthesis.** Purchase of a scalp hair prosthesis when necessitated by hair loss due to the medical condition known as alopecia areata, or as the result of hair loss due to radiation or chemotherapy for diagnosed cancer. Limited to one (1) per Participant per Calendar Year. Subject to approval by Case Management.

Section 8
Limitations and Exclusions on Covered Services

8.1 Limitations and Exclusions

The Plan shall not pay for any service, procedure or supply incurred by the Covered Person, unless it is specifically listed as a Covered Expense under Section 7. The Plan also excludes the following specific items and exclusions:

- **Abortion.** Abortion may be excluded if an Employer adopts a Rider to this Plan Document that specifically provides that the coverage of abortion for any reason is contrary to that Employer's religious tenets. This Rider and notice of such exclusion must be provided to all Covered Persons of the electing Member. If there is a Rider, such exclusion will not apply when the mother's life is endangered by the pregnancy, as well as to complications of abortions.
- **Acupuncture or Acupressure.** Treatment by acupuncture or acupressure.
- **After Termination.** Services or supplies rendered after the termination of coverage, except under an extension of benefits.
- **Alternative Medicine.** Alternative Medicine including but not limited to, hydrotherapy, aromatherapy, naturopathy and homeopathic and holistic treatment.
- **Biofeedback.** All costs associated with Biofeedback.
- **Blood Donor Expenses.** Blood or blood plasma or blood donor expenses, except as specifically covered under Covered Services or as may be deemed Medically Necessary by the Plan Administrator.
- **Charges.** Charges in excess of Allowable Charge.
- **Claim Forms.** Charges for completing claim forms or similar paper work.
- **Complications of Non-Covered Services.** To the extent permitted by law, treatment, service or care required as a result of complications from a treatment or service not covered by the Plan.
- **Cosmetic or Reconstructive surgery**. Services or supplies for Cosmetic or Reconstructive Surgeries and related treatments, including but not limited to:
    - Surgical removal or reformation of sagging skin on any part of the body;
    - Enlargement, reduction or other changes in appearance of any part of the body, unless specifically covered under the Covered Services Section;
    - Hair transplant or removal of hair by electrolysis;
    - Chemical face peels or skin abrasions;
    - Removal of tattoos or birthmarks; and
    - Surgical treatments of scarring secondary to acne or chicken pox to include, but not limited to, dermabrasion, chemical peel, salabrasion, and collagen injections.

      This exclusion shall not apply to Cosmetic or Reconstructive Surgery specifically as listed as a Covered Expense, or as deemed Medically Necessary in connection with an Illness or Injury.
- **Custodial Care.** Custodial Care provided in the home that only assists with the Activities of Daily Living.

- **Dental.** Dental services or supplies and unless specifically listed as a Covered Expense, and in any event limited to the benefits specified in the Plan including:
  - Treatment of natural teeth due to disease;
  - Treatment of natural teeth due to accidental Injury occurring on or after the Effective Date of coverage, unless treatment was sought within 60 days after the Injury and the Participant submitted a treatment plan to Anthem for the prior approval;
  - Dental care, treatment supplies or dental x-rays;
  - Damage to the Participant's teeth due to chewing or biting that is not deemed an accidental Injury and is not covered;
  - Oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures;
  - Appliances for temporomandibular joint pain dysfunction; or
  - Periodontal care, prosthodontic care or orthodontic care.
- **Dentures**. Charges in connection with the fitting or wearing of dentures.
- **Drugs.** Any Drugs covered under the Prescription Drug Card Program will be paid under the Prescription Drug Card Program and not as a Covered Expense under the Plan.
- **Durable Medical Equipment.** Durable Medical Equipment which is not primarily or customarily used to serve a medical purpose, disposable sheaths and supplies, exercise or hygienic equipment, correction appliances (except casts, splints and dressings), support appliances and supplies such as stockings, air conditioners, humidifiers, heating pads, hot water bottles, personal care items, whirlpools, jacuzzis and comfort items.
- **Erectile Dysfunction.** Treatment for Erectile Dysfunction is excluded, except where such sexual dysfunction is caused by surgery (e.g. Prostate surgery), or unless otherwise provided for in the Plan.
- **Examinations.** Examinations for:
  - Employment, insurance, licensing or litigation purposes;
  - Eye refractions;
  - Care and treatment of the teeth, gums or alveolar process; or
  - Sports or recreational activity.
- **Excess Expenses.** Covered Services in excess of the Maximum Benefit.
- **Exercise Programs and Equipment.** All costs related to exercise programs and equipment such as, but not limited to, bicycles and treadmills.
- **Experimental Procedures.** Experimental Procedures as defined in the Glossary.
- **Eye Glasses.** Services or supplies for the purchase or fitting of eye glasses or lenses (except for the first pair of eye glasses and/or contact lenses provided within 1 year of cataract surgery).
- **Fertility/Infertility Treatment.** Charges for all forms of infertility treatment, including but not limited to:
  - Artificial insemination, in vitro fertilization or other artificial methods of conception;

- In vivo fertilization services for a surrogate mother;
- Services to reverse voluntarily induced sterility; and
- Treatment of sexual dysfunctions not related to organic disease.

- **Foot Care**. Routine foot care unless Medically Necessary.
  - **Foot Orthotics**. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
  - **Foot Surgery**. Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; and hyperkeratosis.
- **Foreign Travel.** Foreign travel immunizations.
- **Governmental Benefits.** Governmental Benefits shall include:
  - Hospital services (including room and board), supplies or equipment obtained at government expense at any Veteran's Administration Hospital or any other Hospital owned or leased by the federal government. This exclusion applies only for charges for the treatment of a service-related Disability;
  - Any fee, service or supply received from any governmental body or subdivision thereof and any public or private educational institution;
  - Services or supplies for conditions caused by or arising out of an act of war, armed action, aggression or terrorism; or
  - Care of an Injury or Illness incurred while on active or reserve military duty.
- **Hypnotism.** Hypnotism and hypnotic anesthesia.
- **Late Submittal Claims.** Services or supplies for which a claim is submitted 15 months or more after the date of service in which charges for such services were incurred (see Claims Procedures, Section 12 for more information).
- **Luxury Equipment.** Luxury Medical Equipment when standard equipment is appropriate for the Covered Person's condition (*i.e.* motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).
- **Music Therapy.** Music therapy, remedial reading, recreational therapy and other forms of special education.
- **No Legal Obligation.** Services or supplies for which the Participant or Dependent is not legally obligated to pay or for which no charge would be made in absence of the Plan.
- **Non-Licensed Provider.** Services or supplies provided by a provider, practitioner or institution who or which is not legally licensed to provide those services or supplies in the jurisdiction where such services or supplies were provided.
- **Non-Prescription Drugs.** Drugs, medications and supplies, which do not require a Doctor's prescription and are not otherwise specifically listed as a Covered Expense.
- **Non-Professional Care.** Medical or surgical care that is not performed according to generally accepted professional standards.
- **Not Medically Necessary.** Services or supplies that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.

- **Personal Comfort.** Services or supplies for Personal Comfort or convenience, (i.e. private room, television, telephone, guest trays, etc.).
- **Prior to Effective Date.** Services or supplies rendered prior to the Effective Date of Coverage.
- **Professional Services.** Professional services billed by a Doctor or Nurse while an Employee of a Hospital.
- **Radial Keratotomy or Refractive Keratoplasty.** Radial Keratotomy, Refractive Keratoplasty, lasik and other procedures performed solely for the correction of vision.
- **Related Provider.** Services or supplies provided by persons who ordinarily reside at the same household, or who are related by blood, marriage or legal adoption to the Covered Person.
- **Reversal of Sterilization.** Procedures or treatments to reverse prior voluntary sterilization.
- **Rest Home.** Services provided by a rest home, convalescent facility, or nursing home that only assists with Activities of Daily living such as bathing, dressing, walking, eating, preparing special diets, or supervising the taking of medications.
- **Self-administered Service.** Services administered by the Covered Person.
- **Taxes.** Charges for federal, state and local taxes.
- **Vocational Testing, Evaluation and Counseling.** Vocational and educational services rendered primarily for training or education purposes.
- **Warning Devices.** Warning devices, stethoscopes, blood pressure cuffs or other types of apparatus used for self-diagnosis or monitoring.
- **Workers Compensation or Similar Law.** Services or supplies for any Illness or Injury covered by the Plan for which benefits of any nature are recovered, recoverable or found to be recoverable under Workers' Compensation, any occupational disease law, or any other similar law; or
- **Covered Person's Right to Choose**

The Plan does not limit a Covered Person's right to choose his or her own Medical Care. If a medical expense is not a Covered Expense, or is subject to a Limitation or Exclusion, a Covered Person still has the right and privilege to receive such medical service at the Covered Person's own personal expense. Similarly, if the provider is Out-of-Network, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Coinsurance level with the Covered Person being responsible for a larger percentage of the total medical expense.

Section 9
Coordination of Benefits

If a Covered Person is covered under more than one group plan, benefits will be coordinated. The benefits payable under this Plan for any claim determination period will be either its regular benefits or reduced benefits which, when added to the benefits of the other Plan, will equal 100% of the Allowable Expenses.

9.1 Definitions

The following terms have special meaning in the Coordination of Benefits section:

- **Allowable Expenses.** Any Medically Necessary, Allowable Charges incurred by a Covered Person which is covered at least in part under this Plan.
- **Claim Determination Period.** A Calendar Year or Plan Year or portion of a Calendar Year or Plan Year during which the Covered Person for whom a claim is made has been covered under the Plan.
- **Plan.** Any Plan under which medical or dental benefits or services are provided by:
  - Group, blanket or franchise insurance coverage;
  - Any group Hospital service pre-payment, group medical service pre-payment, group practice or other group pre-payment coverage;
  - Group coverage under labor-management trusted plans, union welfare plans, employer organization plans or employee benefit plans; or
  - Coverage under governmental programs or coverage required or provided by any statute (including no fault auto insurance and personal injury protection), except Medicare. (Refer to the Coordination of Benefits with Medicare provision for treatment of this coverage under this Plan.)

9.2 Effect of Other Health Maintenance Organization (HMO) Coverage

This Plan will not consider as a Covered Expense any charge that is covered by an HMO that is the primary payor. This Plan will not consider any charge in excess of what a primary payor HMO provider has agreed to accept as the reimbursement for a Covered Expense, subject to the Participant's Right to Appeal as described in Section 12.

9.3 Order of Benefit Determination

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expenses. No plan pays more than it would without the Coordination of Benefits provision. A plan without a Coordination of Benefits provision is always the primary plan. If all plans have such a provision:

- This Plan is always secondary to no fault auto insurance or personal injury protection insurance.
- The benefits of the plan which covers the person, on whose behalf a claim is based, as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.
- For claims of a Dependent child of parents not separated or divorced, the plan covering the parent whose birthday occurs earlier in the year pays first. The plan covering the parent whose birthday occurs later in the year pays second.

If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have this birthday rule but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

- For claims of dependent children of parents separated or divorced, the male/female rule and the birthday rule do not apply. Instead:
  - The plan of the parent with primary custody pays first;
  - The plan of the spouse of the parent with primary custody (the step-parent) pays next; and
  - The plan of the parent without custody pays last.

  However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obliged to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first. If any benefits are actually paid or provided before that entity has actual knowledge, this "court decree" rule is not applicable.
- The plan covering a person, on whose behalf a claim is based, as an Employee who is neither laid off nor retired (or as that person's Dependent) pays benefits first. The plan covering a person, on whose behalf a claim is based, as a laid off or retired (or as that laid off or retired person's Dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored; or
- If none of the above rules determines the order of benefits, the plan covering a person, on whose behalf a claim is based, longer pays first. The plan covering that person for the shorter time pays second.

The Coordination of Benefits provision may operate to reduce the total amount of benefits otherwise payable during any claim determination period with respect to a Covered Person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowance Expense and a benefit paid.

9.4 Recovery

If the amount of the payment made by this Plan is more than it should have paid, the Plan has the right to recover the excess from one or more of the following:

- Any person this Plan has paid or for whom it has paid;
- Insurance companies; and
- Other organizations.

9.5 Payment to Other Carriers

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made under any other plan, this Plan will have the right exercisable alone and in its sole discretion to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

Section 10
Coordination of Benefits with Medicare

10.1 Eligibility for Medicare

A Participant may have coverage under the Plan and under Medicare. Medicare means those benefits offered under Title XVIII of the Social Security Act, and includes all of the benefits provided by Parts A and B of Medicare. When a Participant has coverage under both the Plan and Medicare, the Plan will pay primary benefits for:

- An active Employee who is age 65 and over;
- An active Employee's covered spouse age 65 and over;
- An active Employee or covered Dependent of an active Employee under age 65 entitled to Medicare because of a Disability; or
- The first 30 months of treatment for End Stage Renal Disease received by any Participant, as set forth under the Medicare Secondary Payer Act, unless Medicare was already the primary payer for the Participant based on age or Disability prior to the End Stage Renal Disease diagnosis.

If a Participant does not fall into one or more of the categories above, the Plan will pay benefits secondary to Medicare. When the Plan is secondary, the Participant must first submit the claim to Medicare. After Medicare makes payment, the Participant may submit the claim to the Plan for payment.

When a Participant files for Social Security benefits, the Participant automatically becomes eligible for Medicare Part A Hospital coverage, which has no premium expense. A Participant must voluntarily enroll in Medicare Part B medical coverage and pay premiums.

Note: The definition of active Participant for purposes of Medicare is different from the definition of Actively at Work or Employee for purposes of this Plan Document.

10.2 Election by Participant

A Participant, spouse, or Dependent who is covered under Medicare and the Plan, and who falls into the categories above, may elect to waive coverage under the Plan. If an individual waives coverage under the Plan, the Plan will no longer provide coverage for that person. If a Participant elects Medicare as the primary coverage, the Participant will have no further coverage under this Plan.

10.3 HCFA Regulation

This Section is based on regulations issued by the Health Care Financing Administration ("HCFA"), now known as Centers for Medicare and Medicaid Services ("CMS"), and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare Secondary Payer Rules. The Plan will coordinate with Medicare to the fullest extent permitted by applicable law. If the Plan in any way conflicts with regulations issued by CMS, the Plan will pay benefits in accordance with CMS regulations.

Section 11
Subrogation, Reimbursement and Third-Party Recovery

11.1 Benefits Subject to this Provision

This provision shall apply to all benefits provided under any section of this Plan. This provision applies to benefits provided to Participants and Dependents, COBRA beneficiaries, and any other person who may recover on behalf of a Covered Person or beneficiary – including, but not limited to, the Covered Person's attorney, the parents, trustee, guardian or other representative of a minor Covered Person, and the estate of a deceased Covered Person or beneficiary, regardless of whether or not the representative has access or control of the Recovery.

11.2 When this Provision Applies

A Covered Person may incur medical or other charges related to Injuries or Illnesses caused by the act or omission of Another Party including a Doctor or other provider for acts or omissions including but not limited to malpractice; or Another Party may be liable or legally responsible for payment of charges Incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against Another Party for payment of the medical or other charges.

Benefits are payable only upon the Covered Person's acceptance of the terms and conditions of this Plan. The Participant agrees that acceptance of benefits is constructive notice of this section.

The Plan's subrogation right allows the Plan to pursue any claim that the Covered Person has against Another Party, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against Another Party, but in any event, the Plan has an equitable lien on any amount of the Recovery of the Covered Person whether or not designated as payment for medical expenses. Each Covered Person (and/or Covered Person's attorney) agrees to hold any Recovery in constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid the reasonable value of any such benefit paid or payable to, or on behalf of the Covered Person.

11.3 Defined Terms

- **"Another Party"** shall mean any individual, corporation, or entity, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illnesses. Another Party shall include the party or parties who caused the Injuries or Illness (first or third parties); the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; a medical malpractice or similar vaccination or class action fund issue; and any other person, corporation or entity that is liable or legally responsible for payment in connection with the Injuries or Illness.
- **"Recovery"** shall mean any and all money, property, compensation or damages paid or available to the Covered Person by Another Party through insurance payments, settlement proceeds, first or third party payments or settlement proceeds, judgements, reimbursements or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness.
- **"Reimbursement"** or **"Reimburse"** shall mean repayment to the Plan for medical or other benefits paid or payable toward care and treatment of the Illness or Injury and for any other expenses Incurred by the Plan in connection with benefits paid or payable.

- **"Subrogation"** or **"Subrogate"** shall mean the Plan's right to pursue the Covered Person's claims against Another Party for medical or other charges paid by the Plan.

11.4 Subrogation

As a condition to receiving benefits under this Plan, including the payment of future benefits, a Covered Person (and/or the Covered Person's attorney) agrees:

- To execute and deliver to the Plan Administrator a Subrogation and Reimbursement agreement within 30 days of the date of the initial claim. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injuries or Illness before the Subrogation and Reimbursement agreement has been signed; however, in that event, the Plan will still be entitled to Subrogation and Reimbursement according to the terms of this Section;
- To refrain from releasing Another Party that may be liable for or obligated to the Covered Person for an Injury or Illness or condition without obtaining the Plan's written approval; and
- Without limiting the preceding, that the Plan shall be subrogated to any and all claims, causes of action for rights that the Covered Person has or that may arise against Another Party for which the Covered Person claims an entitlement to benefits under this Plan, regardless of how classified or characterized.

The Covered Person shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If a requested Subrogation and Reimbursement Agreement is not executed and returned, or if information and assistance is not provided to the Plan Administrator upon request, the Plan Administrator, in its sole discretion, may deny claims for benefits with respect to costs incurred in connection with said Illness or Injury or terminate Plan coverage in its entirety for the Covered Person and any Dependents. A Covered Person's termination of Plan coverage for the reasons set forth in this provision generally does not constitute a qualifying event within the meaning of COBRA.

If the Covered Person (or legal representative of the Covered Person, including the guardian or estate) decides to pursue a claim against a first or third party for any coverage or damages available to them as a result of the Injury or Illness, the Covered Person agrees to include the Plan's subrogation claim in that action. If there is failure to do so, the Plan will be legally presumed to be included in such action or recovery. In the event the Covered Person decides not to pursue any and all claims against a first or third party for coverage or damages, the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claim in his or her name, to execute any and all documents necessary to pursue said claims in his or her name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person (or other legal representative of the Covered Person, including the guardian or estate) agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, and execute and deliver any acknowledgement and other legal instruments documenting the Plan's subrogation rights. The Plan is responsible for only those legal costs that are related to the Plan's decision to enforce its subrogation rights.

The Plan will not pay, offset any recovery, or in any way be responsible, without its written consent, for any fees, including attorney's fees, or costs associated with a Covered Person or a legal representative of a Covered Person pursuing a claim against a first or third party for any coverage or damages available to them.

Regardless of how a claim, recovery or cause of action is classified or characterized by a party, a court or any other entity, such classification or characterization shall not impact the Covered Person's responsibilities described above or the Plan's entitlement to first-dollar recovery, regardless of whether the Covered Person is made whole. The Plan's subrogation rights override the Covered Person's rights to be made whole. This right of subrogation shall bind the Covered Person, the Covered Person's guardian(s), estate, executor, personal representative, and heirs, COBRA beneficiaries and any other person who may recover on behalf of a Covered Person, including the Covered Person's attorney.

11.5 Reimbursement

As a condition to receiving benefits under this Plan, including the payment of future benefits, a Covered Person (and/or Covered Person's attorney) agrees:

- To execute and deliver to the Plan Administrator a Subrogation and Reimbursement agreement within 30 days of the date of the initial claim. The Covered Person's attorney must recognize and consent to the fact that the Plan precludes operation of the "made-whole" and "common fund" doctrines, and the attorney must agree to not assert either doctrine in his or her pursuit of Recovery. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injuries or Illness before the Subrogation and Reimbursement agreement has been signed; however, in that event, the Plan will still be entitled to Subrogation and Reimbursement according to the terms of this Section;
- To notify the Plan Administrator immediately in writing of any proposed settlement and obtain the Plan's written consent before signing a settlement agreement;
- To notify the Plan Administrator immediately in writing if any recovery is received by or on behalf of a Covered Person from Another Party that may be liable for or obligated to the Covered Person for an Injury or Illness or condition (without regard to admission of fault);
- To serve as a constructive trustee and to hold in constructive trust for the benefit of the Plan any Recovery, without regard to admission of fault, equal to the reasonable value of benefits paid or that will be paid by the Plan. The Covered Person agrees not to dissipate any such money or property without prior written consent of the Plan, regardless of how such money or property is classified or characterized or regardless of any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies or funds from which such money or property was received;
- To restore to the Plan the reasonable value of any such benefit paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by Another Party; and
- To refrain from releasing Another Party that may be liable for or obligated to the Covered Person for an Injury or Illness or condition without obtaining the Plan's written approval.

The Covered Person shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If a requested Subrogation and Reimbursement Agreement is not executed and returned, or if information and assistance is not provided to the Plan Administrator upon request, the Plan Administrator, in its sole discretion, may deny claims for benefits with respect to costs incurred in connection with said Illness or Injury or terminate Plan coverage in its entirety for the Covered Person and any Dependents. A Covered Person's termination of Plan coverage for the reasons set forth in this provision generally does not constitute a qualifying event within the meaning of COBRA.

The Plan will not pay, or in any way be responsible, without its written consent, for the Covered Person's or his/her legal representative's attorney's fees and costs associated with the recovery of funds or pursuit of a claim against a first or third party for any coverage or damages available to them, nor will it reduce its reimbursement pro rata for the payment of the Covered Person's or his/her legal representative's attorney's fees and costs. Attorneys' fees may be payable from the recovery only after the Plan has received full reimbursement.

An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this Section. A Covered Person's attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the Covered Person nor his attorney is the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

Regardless of how a claim, recovery or cause of action is classified or characterized by a party, a court or any other entity, such classification or characterization shall not impact the Covered Person's responsibilities described above or the Plan's entitlement to first-dollar recovery, regardless of whether the Covered Person is made whole. The Plan's reimbursement rights override the Covered Person's rights to be made whole. This right of reimbursement shall bind the Covered Person, Covered Person's guardian(s), estate, executor, personal representative, and heir(s), COBRA beneficiaries and any other person who may recover on behalf of a Covered Person, including the Covered Person's attorney.

If a Covered Person fails to reimburse the Plan for the reasonable value of benefits paid or to be paid, as a result of their Illness or Injury, out of any such recovery or reimbursement, the Covered Person (or the Covered Person's designee) will be liable for any and all expenses (including attorney's fees or costs) associated with the Plan's attempt to recover such amount from the Covered Person.

11.6 Constructive Trust

The Covered Person (and/or Covered Person's attorney), by accepting benefits under this Plan, agrees:

- To hold in constructive trust for the Plan's benefit any money or property resulting from any recovery, insurance payments or settlement proceeds, first or third party payments, settlement proceeds or judgment, without regard to admission of fault, and that the Plan has an equitable lien by agreement over any such recovery in an amount equal to the reasonable value of benefits paid or that will be paid by the Plan to the Covered Person under this Section; and
- The Covered Person further agrees to hold such amounts separately and without commingling with the Covered Person's (or the Covered Person's designee's) general assets.

The Covered Person acknowledges that the Plan has a property interest in the Covered Person's settlement, recovery, or reimbursement, and that the Plan's reimbursement rights shall be considered a first priority claim if the Plan pays primary and shall be paid before any other claims for the Covered Person as the result of the Injury or Illness, regardless of whether the Covered Person is made whole. If a Covered Person fails to reimburse the Plan for the reasonable value of benefits paid or to be paid, as a result of their Illness or Injury, out of any such recovery or reimbursement, the Covered Person (or the Covered Person's designee) will be liable for any and all expenses (including attorney's fees or costs) associated with the Plan's attempt to recover such amount from the Covered Person. This right of reimbursement shall bind the Covered Person, Covered Person's guardian(s), estate, executor, personal representative, and heir(s), COBRA beneficiaries and any other person who may recover on behalf of a Covered Person, including the Covered Person's attorney. A Covered Person's failure to observe the obligations in this provision may result in the termination of Plan coverage for the Covered Person, including any Dependents' coverage, in the Plan Administrator's sole discretion. A Covered Person's termination of

coverage for the reasons set forth in this provision generally does not constitute a qualifying event within the meaning of COBRA.

Any amounts subject to a constructive trust under this section shall be limited to amounts received by the Covered Person or their legal representative for said Injury or Illness. Any recovery made by the Plan under this section shall be limited to the reasonable value of medical expenses and other fees and costs, including attorney's fees, paid by or payable by the Plan for said Injury or Illness.

11.7 Rights of Recovery

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment from the Covered Person or, if applicable, the provider or otherwise make appropriate adjustments to claims. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician or other provider of health care, and the payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider

11.8 Right to Receive and Release Necessary Information

For the purpose of implementing the terms of this Plan, the Plan Administrator retains the right to request any medical information from any insurance company or other provider of service it deems necessary to properly process a claim in its sole discretion. The Plan Administrator may, in its sole discretion and without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Section 12
Claims and Payments

A charge is incurred on the date a service is provided. The Participant must be actively enrolled on the date the service is provided to file a claim with the Plan. Also, the dates of service will affect the Participant's Deductible (if any) and other minimums described in the associated SBCs and in this Section.

12.1 Out-of-Network Calendar Year Deductible

The Participant's Benefits include a Calendar Year Deductible for services that the Participant receives Out-of-Network. Before the Plan will make payments for services received Out-of-Network, the Participant must first satisfy the Calendar Year Deductible. See the attached Schedule of Benefits section of this Plan for the Participant's Calendar Year Deductible amounts.

Services received during the last 3 months of the Calendar Year that applied to a Covered Person's Deductible, may also apply to the medical Deductible (excluding the Prescription Deductible) required for the following Calendar Year.

12.2 Participant's Out-of-Pocket Expense Maximums

This Plan protects the Participant from large Out-of-Pocket Expenses by limiting the amount the Participant spends out of the Participant's own pocket each year. Once the maximum on the Participant's Plan is reached, almost all other Covered Services are paid in full for the rest of the Plan Year.

12.3 What the Participant Will Pay

- **In-Network Maximum.** Copayments and Coinsurance for services by providers and facilities within the Participant's Network count toward the In-Network, Out-of-Pocket Maximum. When the Participant's In-Network, Out-of-Pocket Maximum is reached, Copayments and Coinsurance for In-Network Services will no longer apply for the rest of the Calendar Year. Two special situations when expenses will also count toward this maximum are:
    - When the Participant receives services from medical suppliers for whom there is no Network (e.g. private duty nurses), the Participant's Out-of-Pocket Expense's count toward this maximum; and
    - When specialty care is not available within the Network and Anthem authorizes the highest level of benefits, any Copayment and Coinsurance for these services count toward this maximum.
- **Out-of-Network Maximum**. Deductibles and Coinsurance for services by providers and facilities who are not part of the Participant's PPO Network, but who participate in an Anthem or Blue Cross and Blue Shield Company's Network, count toward the Participant's Out-of-Network, Out-of-Pocket Maximum. If the Participant reaches the Out-of-Network, Out-of-Pocket Maximum, the Participant will no longer pay Coinsurance for Out-of-Network Services for the rest of the Calendar Year.

Helpful tip: The In-Network and Out-of-Network, Out-of-Pocket Maximums are separate, and amounts applied to one do not apply to the other.

12.4 Exceptions to the Out-of-Pocket Maximum

The following amounts do not count toward the Participant's Out-of-Pocket Maximum, and the Participant will always be responsible for these expenses, regardless of whether the Participant has met the Out-of-Pocket Maximum:

- Amounts above the Allowable Charge (these amounts are not the patient's responsibility when services are rendered by a Network or Participating Provider or facility);
- Amounts above Plan maximums;
- Copayments and Coinsurance for Prescription Drugs under the Participant's prescription drug card benefit (under Plans 2-5, see the associated SBCs for additional information);
- Medical Deductible amounts carried forward from the prior Calendar Year (excluding the Prescription Deductible);
- Expenses for supplies or services not covered by the Plan; and/or
- Deductibles, Copayments, and Coinsurance for dental services provided by separate contract, certificate, or amendment to this Plan.

12.5 Payment of Claims

- **Network and Participating Providers and Facilities.** If the Participant goes to a Network provider or facility, the Plan Administrator will pay the provider or facility directly. If a Copayment or Coinsurance is applicable to services rendered by a Network provider, or if any applicable Deductible is not met, any such amounts may be collected at the time of service. Any applicable Coinsurance is based on Anthem's negotiated payment arrangement with the facility or provider.
- **Non-Participating Providers and Facilities.** If the Participant goes to a non-Participating Provider or facility, the Plan Administrator may choose to pay Participant or anyone else responsible for paying the bill. The Plan Administrator will pay only after receiving an itemized bill or proof of loss and all the medical information necessary to process the claim. The Plan Administrator will not pay a non-Participating Provider more than the amount the Plan Administrator would have paid a Participating Provider for the same service.

In the event that payment is made directly to the Participant, the Participant has the responsibility to apply this payment to the claim from the non-Participating Provider. In all cases, payment from the Plan relieves Anthem and the Plan of any further liability for the service.

12.6 When Participant Must File a Claim

Network providers file claims on the Participant's behalf. A Participant may have to file a claim if he or she receives care from an Out-of-Network provider or facility.

The Participant will also have to file a claim if services were billed by someone other than a Physician or Hospital, or if the provider cannot file a claim for the Participant. To file a claim, the Participant should:

- Obtain a claim form from Member Services;
- Compile any itemized bills for the services; and
- Send the completed claim form and any itemized bills compiled to Member Services:

  Each itemized bill must contain the following:

  - Name and address of the person or organization providing services or supplies;

- Name of the patient receiving services or supplies;
- Date on which services or supplies were provided;
- The charge for each type of service or supply;
- A description of the services or supplies received; and
- A description of the patient's condition (diagnosis).

- In addition, private duty nursing bills must include the professional status of the nurse (for example, RN for registered nurse), the attending Physician's written certification that the services were Medically Necessary, and the hours the nurse worked.

12.7 Timely Filing of Claims

Written proof of loss must be furnished within 90 days, or as soon as reasonably possible, after the date of service. However, no claim will be paid if Member Services receives the proof of loss more than 15 months after the date of service, except in the absence of legal capacity of the Covered Person. A proof of loss is not complete unless it is properly filed and contains all information that Member Services needs to process the claim.

12.8 Complaint and Appeal Process

In order to remain responsive to Participants' needs, the Plan has established both a complaint process and an appeal process. Participants should contact the Plan Administrator or a Member Services representative if any problems or questions arise regarding the Plan. The contact telephone number for Member Services is listed on the back of the Participant's identification card. Most problems and questions can be handled in this manner.

The Participant may also file a written complaint or appeal with the Plan Administrator or Member Services. Complaints typically involve issues such as dissatisfaction about the Plan's services, quality of care, the choice of and accessibility to the Plan's providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by the Plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

12.9 Complaint Process

Complaints may be registered by telephone or in writing. Upon receipt, the complaint will be reviewed and investigated. The Participant will receive a response within 30 calendar days of the Plan's receipt of the complaint. If the Plan is unable to resolve the complaint in 30 calendar days, the Participant will be notified on or before calendar day 30 that more time is required to resolve the complaint. The Plan will then respond within an additional 30 calendar days.

Complaints made over the phone may be made to Member Services using the phone number on the back of the Participant's identification card.

Complaints made in writing may be delivered to the following address:

Tim Klopfenstein, Executive Director
Virginia Private Colleges Benefits Consortium, Inc.
1 Cedar Hill Court, Suite D
Bedford, VA 24523

12.10 Claims Procedures

There are different types of claims that can be made under the Plan, each with somewhat different claim and appeal rules. If You have any questions regarding what type of claim and/or what claims procedure to follow, please contact Member Services.

12.10.1 Types of Claims and Timeframes for Deciding Initial Claims

- **Pre-Service Claims** are claims for a service that require the Covered Person to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If the Covered Person calls to receive authorization for a service when authorization in advance is not required, the claim will be considered a Post-Service Claim. As outlined in Section 3, The Preauthorization Process, the Plan will make Pre-Service Claims decisions within 15 days from the receipt of the request.
- **Post-Service Claims** are all claims other than Pre-Service, Urgent Care Claims, or Concurrent Care/Ongoing Course of Treatment Claims. Post-Service Claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where the Covered Person requests authorization in advance. The Plan will make Post-Service Claims decisions within a reasonable time, but no later than 30 days and may be extended for another 15 days if it is determined to be necessary because of matters beyond Member Services control.
- **Urgent Care Claims** are claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's Physician, would subject the patient to severe pain. The Plan will defer to the patient's Physician as to whether a claim involves urgent care. As outlined in Section 3, The Preauthorization Process, the Plan will make Urgent Care Claims decisions within 72 hours after receipt of the Claim. In cases where the Hospital admission is an Urgent Care Claim, a decision will be made within 24 hours and the Participant's Doctor will be notified verbally of the decision within this time frame.
- **Concurrent Care Claims/Ongoing Course of Treatment Claims** are claims where the Plan approves an Ongoing Course of Treatment to be provided over a period of time for a specified number of treatments. There are two types of Concurrent Care Claims: (a) where reconsideration of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments. As outlined in Section 3.10, Approvals of Care Involving an Ongoing Course of Treatment, the Plan will make Concurrent Care Claims decisions to extend a previously approved course of treatment within 24 hours of the request, when the request is made at least 24 hours prior to the end of the authorized time frame to avoid disruption of care or services. Please see Section 3.10, for more information.

In processing the Participant's claim, the Plan may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the "When Participant Must File a Claim" paragraph of this Section will be processed within 30 days of receipt of the claim. This period may be extended for another 15 days if it is determined to be necessary because of matters beyond Member Services control. In the event that this extension is necessary, the Participant will be notified prior to the expiration of the initial 30-day period. If the decision involves a determination of the appropriateness or Medical Necessity of Services,

Member Services will make a decision within 2 working days of the receipt of the medical information needed to process the claim.

12.10.2 Notification of Initial Benefit Decision

The Plan may deny a claim for Benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by the Participant or the Participant's provider by furnishing the additional information. The Participant or the Participant's provider must submit the additional information to us within either 15 months of the date of service or 45 days from the date the Participant was notified that the information is needed, whichever is later. Once the Participant's claim has been processed by the Plan, the Participant will receive written notification of the decision. In the event of an Adverse Benefit Determination, notice will be provided to the Participant in a culturally and linguistically appropriate format that is calculated to be understood by the Participant. The written notification will include the following:

- Information sufficient to allow the Participant to identify the claim involved (including the date of service, the healthcare provider, the claim amount, and, if applicable, the treatment code and its corresponding meaning);
- The specific reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- Reference to the specific plan provisions on which the determination was based;
- A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external appeal procedures. This description will include information on how to initiate the appeal and the time limits applicable to such procedures. This will include a statement of the Participant's right to bring a civil action following a Final Adverse Benefit Determination;
- If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the Participant upon request;
- If the Adverse Benefit Determination is based on the Medical Necessity or experimental nature of the care or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request; and
- Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and External Review process.

If all or part of a claim was not covered, the Participant has a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the Plan relied upon in making the coverage decision. If a decision was based on Medical Necessity or the experimental nature of the care, the Participant is entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to Participant's medical condition.

12.11 Appeal Procedures

The Plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions the Participant finds unacceptable, whether the decision is a claim denial or a rescission of coverage. A rescission is a retroactive termination of coverage, other than when it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. The Plan will not make decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to claims adjudicators or medical experts based upon the likelihood that such individuals will support or tend to support a denial of benefits.

Internal appeals are requests to reconsider rescissions or coverage decisions of Pre-Service or Post-Service Claims. Expedited appeals of Urgent Care Claims are made available when the application of the time period for making Pre-Service or Post-Service appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's Physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain.

12.12 First Level of Appeal – Internal Appeals

To appeal a coverage decision, including a rescission, the Participant should send a written explanation of why the Participant feels the coverage decision was incorrect. The Participant or the Participant's authorized representative acting on the Participant's behalf must submit the written explanation. Alternatively, this information may be provided to a Member Services representative over the phone. This is the Participant's opportunity to provide any comments, documents, or information that the Plan should consider when reviewing the appeal. Please include with the explanation:

- The patient's name, address and telephone number;
- The Participant's identification and group number (as shown on the Participant's identification card); and
- In the case of a claim, the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

Important: For appeals, Participants should contact Member Services at the following address:

In Writing:

Anthem Blue Cross and Blue Shield
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

By Telephone for all Members:

833-597-2358

For CarelonRx

In Writing:

CarelonRx
P.O. Box 52065
Phoenix, AZ 85072

By Telephone: 833-389-1968

Appeals must be filed within either 15 months of the date of service or 180 days of the date the Participant was notified of the Adverse Benefit Determination, whichever is later.

12.12.1 Expedited Appeals of Urgent Care Claims

In light of the expedited timeframes for deciding of Urgent Care Claims, a Participant that wants to appeal an Urgent Care Claim should contact Member Services at the number shown on the back of the Participant's 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.

12.13 Action on Appeal

In reviewing an appeal, the Plan will take into account all the information submitted, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing the appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving Medical Necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff. The Plan will resolve and respond in writing to the appeal within the following time frames:

- For Pre-Service Claims, the Plan will respond in writing within 30 days after receipt of the request to appeal;
- For Post-Service Claims and rescissions, the Plan will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals of Urgent Care Claims, the Plan will respond to the Participant and the Participant's provider as soon as possible taking into account the medical condition, but not later than 72 hours from the receipt of the request.

The Plan will also provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim. In addition, before the Participant receives an Adverse Benefit Determination based on new or additional rationale, the Plan will provide the Participant, free of charge, with the rationale to give the Participant a reasonable opportunity to respond.

When the review of the appeal has been completed, the Participant will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based; this written notification is the final Adverse Benefit Determination. The Participant will also be entitled to receive, upon request and at no charge, the following:

- Reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- Any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- The explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- The identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's Adverse Benefit Determination, whether or not the advice was relied upon.

12.14 Second and Final Level of Appeal – External Review

If the outcome of the appeal is adverse to the Participant, the Participant may be eligible for an independent external review pursuant to federal law. The Participant must submit a request for external review to the Plan within 4 months of the notice of the final Adverse Benefit Determination. A request for external review must be in writing unless the Plan determines that it is not reasonable to require a written statement. The Participant does not have to re-send the information that was submitted as part of the internal appeal. However, the Participant is encouraged to submit any additional information that might be important for review.

Expedited external review requests are to be initiated by telephone

For Urgent Care Claims or Concurrent Care/Ongoing Course of Treatment claims, the Participant may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. The Participant or the Participant's authorized representative may formally request it orally or in writing, but in order to support the fastest review the Participant must call Member Services. All necessary information, including the Plan's decision, can be sent between the Plan and the Participant by telephone, facsimile or other similar method. To start an expedited external review, the Participant or the Participant's authorized representative must contact the Plan at the Member Services number shown on the back of the Participant's 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.

Other external review requests

All other requests for external review should be submitted in writing unless the Plan determines that it is not reasonable to require a written statement. Such requests should be submitted by the Participant or the Participant's authorized representative to:

Tim Klopfenstein, Executive Director
Virginia Private Colleges Benefits Consortium, Inc.
1 Cedar Hill Court, Suite D
Bedford, VA 24523

The Participant's decision to seek external review will not affect the Participant's rights to any other benefits under this health care plan. There is no charge for the Participant 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.

12.15 Timeframe for Deciding Benefit Appeals

The Named Fiduciary shall decide the appeal within the same timeframe as set forth in Sections 12.13 above.

12.16 Decision by the Named Fiduciary

The decision of the Named Fiduciary will be final and binding and will only be subject to review if such decision was arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Named Fiduciary shall be based only on such evidence presented to or considered by the Named Fiduciary at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decision that the Named Fiduciary makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described in this Section.

12.17 Notice in Writing

Any legal notice given to the Plan must be in writing and delivered to: Tim Klopfenstein, Executive Director, Virginia Private Colleges Benefits Consortium, Inc., 1 Cedar Hill Court, Suite D, Bedford, VA 24523. Notice given to a Covered Person will be sent to the Covered Person's address as it appears in the Plan's records. Anthem, CarelonRx, the Plan Administrator, or a Covered Person may indicate a new address for giving notice.

12.18 Administrative Record

In any action for the recovery of benefits, the evidence which may be submitted for review shall be limited to the administrative record on the claim or appeal. Participants may not submit new arguments or theories of recovery in litigation.

12.19 Time Limits on Legal Action

No legal action on a claim may be brought against Anthem, CarelonRx, the Plan or the VPC Benefits Consortium until all appeal rights with respect to the claim have been exhausted. No legal action on a claim may be brought more than one year following the date that all appeal rights with respect to the claim have been exhausted. This limit applies to matters relating to this Plan, to our performance under this Plan, or to any statement made by an Employee, officer, or director of Anthem or CarelonRx concerning this Plan or the benefits available to a Covered Person.

12.20 Failure to File an Appeal

The Plan's internal appeals procedure (but not an external review) must be exhausted before filing a lawsuit or taking other legal action of any kind against the Plan. The Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). If an appeal, as described above, results in an Adverse Benefit Determination, the claimant has a right to bring a civil action under Section 502(a) of ERISA. The Plan reserves the right to modify the policies, procedures and time frames in this section upon further clarification from Department of Health and Human Services and Department of Labor.

12.21 Administrative Exhaustion Requirement

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought including a claim for benefits or for breach of fiduciary duty.

The Plan's internal appeals procedures can be deemed exhausted, however, and the claimant will be permitted to proceed to external review or judicial review, if the Plan fails to strictly adhere to the internal claims and appeals processes set forth in this Section.

The internal claims and appeals processes, however, will not be deemed exhausted if the Plan's noncompliance was (1) de minimis; (2) non-prejudicial; (3) attributable to good cause or matters beyond the Plan's control; (4) in the context of an ongoing good-faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. Upon written request, the Plan will, within 10 days, include a specific description of the bases for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If the external reviewer or the court rejects the claimant's request for immediate review (based on a finding that the Plan met this standard) the Plan will provide the claimant notice of the opportunity to resubmit and pursue the internal appeals of the claims. The notice will be sent within a reasonable time after the external reviewer rejects the claims for immediate review, but not later than 10 days.

12.22 Limitations of Damages

In the event a Covered Person or his representative sues Anthem, CarelonRx, the Plan or the VPC Benefits Consortium, or any of its directors, officers, or Employees acting in his or her capacity as director, officer, or Employee, for a determination of what coverage and/or benefits, if any, exist under this Plan, the damages shall be limited to the amount of the Covered Person's claim for Benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed.

12.23 The Plan's Continuing Rights

On occasion, the Plan may not insist on the Participant's strict performance of all terms of this Plan. This does not mean the Plan gives up any future rights it has under this Plan.

12.24 Relationship to Providers

The choice of a health care provider is solely the Covered Person's. Providers are neither Employees nor agents of Anthem, the Plan or the VPC Benefits Consortium. Anthem, the Plan or the VPC Benefits Consortium can contract with any appropriate provider or facility to provide services to the Participant. The inclusion or exclusion of a provider or a facility in any Network is not an indication of the provider's or facility's quality or skill. No guarantees are made about the healthcare provided by any providers. Neither Anthem nor CarelonRx furnishes services but only makes payment for them when received by Covered Persons.

Anthem, CarelonRx, the Plan and the VPC Benefits Consortium are not liable for any act or omission of any provider, nor is Anthem, CarelonRx, the Plan or the VPC Benefits Consortium responsible for a provider's failure or refusal to render services to a Covered Person.

12.25 Assignment of Payment

A Covered Person may not assign the right to receive payment for services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not waive or otherwise restrict Anthem's, CarelonRx's, the Plan's or the VPC Benefits Consortium's right to direct future payments to a Covered Person or any other entity. This provision does not apply to Dentists and oral surgeons.

Once services are rendered by a provider, Anthem, CarelonRx, the Plan and the VPC Benefits Consortium will not honor requests not to pay the claims submitted by the provider. Anthem, CarelonRx, the Plan and the VPC Benefits Consortium will have no liability to any person because it rejects the request.

Section 13
Statement of ERISA Rights

Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Participants shall be entitled to:

13.1 Receive Information About Participant's Plan and Benefits

Participants may examine, without charge, at the Plan's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Participants may obtain, upon written request to Tim Klopfenstein, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The VPC Benefits Consortium may make a reasonable charge for the copies.

Participant may receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the VPC Benefits Consortium is required by law to furnish each Participant with a copy of this summary annual report.

13.2 Enforce Participant's Rights

If Participant's claim is denied or ignored, in whole or in part, Participant has the right to know why this was done, to obtain copies of document relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Covered Person can take to enforce his or her rights. For instance, if a request for Plan documents is made to the Plan Administrator and such requested information is not received within 30 days, Participant may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until such requested information is received by the requesting Covered Person, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. Additionally, if a claim for benefits is denied or ignored, in whole or in part, and if Participant has exhausted the claims procedures available to Participant under the Plan as described in Section 12, Participant may file suit in federal court.

13.3 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Participant's Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Participant and other Plan Participants and beneficiaries. No one, including Participant's Employer or any other person, may fire Participant or otherwise discriminate against Participant in any way to prevent Participant from obtaining a Plan benefit or exercising Participant's rights under ERISA.

If it should happen that Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his or her rights, then such Participant may seek assistance from the U.S. Department of Labor, or file suit in federal court. The court will decide who should pay court costs and legal fees. If a Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order such Covered Persons to pay these costs and fees, for example, if the court finds the claim is frivolous.

13.4 Questions

If Participant has any questions about the Plan, Participant should contact the VPC Benefits Consortium. If Participant has any questions about this statement, or about their ERISA rights, or if they need assistance in obtaining documents from the Plan Administrator, Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20220. Participant may also obtain certain publications about Participant's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 14
General Provisions

14.1 Verification

The Plan Administrator shall be entitled to require reasonable information to verify any Claim or the status of any person as a Covered Person. If the Covered Person does not supply the requested information within the applicable time limits or provide a release for such information, such Covered Person shall not be entitled to benefits under the Plan.

14.2 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against a Member, the Board of Directors of the Association, any of their employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related Trust, except as expressly provided herein or as provided by law.

14.3 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

14.4 Captions

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall the captions affect the Plan or the construction of any provision thereof.

14.5 Construction

Any words herein used in the masculine shall also include the feminine and neutral where they would so apply. Words in the singular shall also include the plural and vice versa where they would so apply.

14.6 Entire Plan

This document and the associated SBCs and SOBs constitute the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing.

14.7 Non-Guarantee of Employment

Nothing contained in the Plan shall be construed as a contract of employment between a Member and any Participant, or as a right of any Participant to be continued in the employment of a Member, or as a limitation of the right of a Member to discharge any of the Participants, with or without cause.

14.8 Governing Law

This Plan Document shall be governed by and construed and enforced with the laws of the Commonwealth of Virginia, to the extent not preempted by ERISA or other federal law.

14.9 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the IRS, we inform Participant that to the extent this communication (including any attachments) contains advice relating to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of (i) avoiding any penalties that may be imposed on Participant or any other person or entity under the Internal Revenue Code; or (ii) promoting, marketing or recommending to Another Party any transaction or matter addressed herein. If Participant is not the original addressee of this communication, Participant should seek advice from an independent advisor based on the particular circumstances.

Section 15
Plan Administrator Duties and Powers

15.1 Appointment of Plan Administrator

The VPC Benefits Consortium shall appoint a Plan Administrator to administer the Plan and keep records of proceedings and Claims. The Plan Administrator will serve until resignation or dismissal by the VPC Benefits Consortium. Any vacancy or vacancies shall be filled in the same manner as the original appointments. The VPC Benefits Consortium may dismiss any person or persons serving as Plan Administrator at any time with or without cause. In the event the VPC Benefits Consortium chooses to appoint more than one person to act as Plan Administrator, a majority vote of such shall be necessary for the transaction of business. In the event 2 persons are named as Plan Administrator, the transaction of business shall require the unanimous vote of both parties.

15.2 Powers of Plan Administrator

Subject to the limitations of the Plan, the Plan Administrator will from time to time establish rules for the administration of the Plan and transaction of its business. The Plan Administrator will rely on the records of the Members with respect to any and all factual matters dealing with the employment and eligibility of an Employee. The Plan Administrator will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions hereunder, including, but not limited to, the sole and absolute discretion to:

- Construe and interpret the Plan;
- Decide the questions of eligibility to participate in the Plan; and
- Determine the amount, manner and time of payment of any benefits to any Covered Person.

The Plan Administrator will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding.

15.3 Outside Assistance

The Plan Administrator may employ such counsel, accountants, Claims Administrators, consultants, actuaries and other person or persons, as the Plan Administrator shall deem advisable. The VPC Benefits Consortium shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan.

15.4 Delegation of Powers

In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable the Plan Administrator to properly carry out such duties. The Plan Administrator as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the Plan other than expressly provided in this Section.

Section 16
Amendments, Terminations and Mergers

16.1 Right to Amend, Merge or Consolidate

The VPC Benefits Consortium reserves the right to merge or consolidate the Plan, and to make any amendment or amendments to the Plan from time-to-time, including those which are retroactive in effect. Such amendments may be applicable to any Covered Person.

Any amendment shall be deemed to be duly executed by the VPC Benefits Consortium when approved by the Board of Directors. This approval shall be drafted in a Board Resolution that is to be signed by either the President or Vice-President, and attested by the Secretary or Treasurer.

16.2 Right to Terminate

The Plan is intended to be permanent, but the VPC Benefits Consortium may at any time terminate the Plan in whole or in part.

16.3 Effect on Benefits

Except as may otherwise be provided by applicable law or this Plan Document, if the Plan is amended or terminated, Covered Persons may not receive benefits described in the Plan after the Effective Date of such amendment or termination. Any such amendment or termination shall not affect a Covered Person's right to benefits for claims incurred prior to such amendment or termination. If the Plan is amended, Covered Persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA or other continuation benefits. This may happen from time to time. If the Plan is terminated, Covered Persons will not be entitled to any vested rights under the Plan.

Glossary

The following terms, as used in the Plan, shall have the meaning specified in this Glossary, unless a different meaning is clearly required by the context in which it is used:

Actively at Work shall mean performing the Employee's job at the location where the Employee generally reports to work. If such Employee is on vacation, Approved Leave of Absence, Approved Sabbatical, Approved Disability Leave, or is off due to a holiday or other reason approved by the Employer, the Employee will be deemed Actively at Work if the Employee was Actively at Work on the day immediately prior to the vacation, Approved Leave of Absence, Approved Sabbatical, Approved Disability Leave, holiday, or other Employer-approved reason.

Activities of Daily Living shall refer to the following, with or without assistance:

- Bathing, which is the cleansing of the body in either a tub, shower or by sponge bath;
- Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting, which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
- Transferring, which is to move in and out of a bed, chair, wheelchair, tub or shower;
- Mobility, which is to move from one place to another, with or without the assistance of equipment;
- Eating, which is getting nourishment into the body by any means other than intravenous; and
- Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

Adverse Benefit Determination means a claim that is denied, in whole or in part, or if Plan coverage is rescinded retroactively on the basis of fraud or misrepresentation.

Allowable Charge means the amount on which Deductible (if any), Copayment, and Coinsurance amounts for eligible services are calculated, as further defined in Section 3.

Ambulatory Care shall mean services provided in an Ambulatory Care Facility.

Ambulatory Care Facility shall mean a facility that provides Outpatient Care.

Ambulatory Surgical Facility shall mean an ambulatory surgical center, free-standing surgical center, or Outpatient surgical center, which is not part of a Hospital and which:

- Has an organized medical staff of Doctors;
- Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- Has continuous Doctor's services and registered nursing (R.N.) services whenever a patient is in the facility;
- Is licensed by the jurisdiction in which it is located; and
- Does not provide for overnight accommodations.

Applied Behavioral Analysis shall mean the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Approved Disability Leave shall mean an approved leave for purposes of Disability for the period of time approved and designated by the Member as a short-term disability leave for the Employee for a period not to exceed one year. For purposes of this Section, the term "Disability" shall mean that the Employee is not able to perform the duties of the Employee's regular occupation with the Member, as determined in the sole discretion of the Plan Administrator.

Approved Leave of Absence shall mean an Approved Leave of Absence for a period not to exceed 12 consecutive months, with the stated intention of returning to full time employment with the Member. For purposes of this document the term Approved Leave of Absence shall not refer to leave under the Family and Medical Leave Act.

Approved Sabbatical shall mean an approved paid sabbatical or fellowship for a period not to exceed 12 consecutive months. Participant must be covered prior to Effective Date of Leave.

Attained Age shall mean the age in years of a Covered Person as of the last anniversary of his date of birth.

Bariatric Surgery shall have the same meaning as set forth in the VPC Benefits Consortium Bariatric Surgery Policy, available from the Plan Administrator.

Benefit Year shall mean the Plan Year.

Benefit Year Maximum Benefit shall mean the maximum amount of Incurred Charges rendered within a specific Benefit Year, which shall be paid by the Plan.

Birthing Center shall mean a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Doctors specializing in obstetrics, gynecology, or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Calendar Year shall mean January 1 to December 31 of each year.

Case Management is a program in which a case manager monitors the Covered Person to explore and/or discuss alternative or other coordinated types of Medical Care available.

Claims Administrator shall mean the person or persons appointed by the Plan Administrator to determine benefit eligibility and to adjudicate claims under the Plan.

COBRA shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Coverage or Continuation Coverage shall mean the continuation of health care benefits for Participants and Dependents on the occurrence of a qualifying event as defined by COBRA, and as further set forth in the Continuation of Coverage Section.

Code shall mean the Internal Revenue Code of 1986, as amended.

Coinsurance shall mean the percentage of an Allowable Charge that a Covered Person pays after the satisfaction of any applicable Deductible.

Complications of Pregnancy shall mean:

- Conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, abortion where the life of the mother is endangered and complications of abortion and similar medical and surgical conditions of comparable severity;
- Non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Concurrent Care Claims/Ongoing Course of Treatment Claims shall mean claims where the Plan approves an ongoing course of treatment to be provided over a period of time for a specified number of treatments. There are two types of Concurrent Care Claims: (a) where reconsideration of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments.

Congenital Defects shall mean newborn coverage including coverage for Injury or Illness, and the necessary care or treatment of medically diagnosed Congenital Defects, birth abnormalities, anomalies, including cleft lip or cleft palate or prematurity.

Continuation Coverage Payments shall mean the payments required for COBRA Continuation Coverage.

Copayment shall mean the Covered Person's portion of the payment for certain Covered Services indicated in the associated SBCs. This payment may be requested at the time of service. Copayments do not count toward the satisfaction of Deductibles or Out-of-Pocket Maximums.

Cosmetic Treatment or Surgery shall mean medical or surgical procedures to alter normal structures of the body in order to improve appearance, treat a Mental Health Condition or to improve self-esteem.

Covered Person shall mean a Participant or Dependent covered under the Plan.

Covered Services shall mean those services listed as covered in the Covered Services Section 7.

Custodial Care shall mean non-medical aid consisting of services and supplies, provided to an individual in or out of an institution, primarily to assist such person in Activities of Daily Living, whether or not disabled.

Day Treatment (or Partial Hospitalization) shall mean an Outpatient treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting, which shall be no less favorable than an exchange of 1.5 days of Partial Hospitalization for each day of coverage. The program is designed to treat patients with serious mental, nervous and chemical dependency disorders and offers major diagnostic, psycho-social and prevocational modalities. Such programs must be in a less restrictive, less expensive alternative to Inpatient treatment.

Deductible is a fixed dollar amount of Covered Services You pay in the Calendar Year before the Plan will pay for certain benefits as specified in the applicable associated SBCs.

Dentist shall mean an individual licensed as a Dental Practitioner in the jurisdiction where services are provided.

Dependent shall mean any person described below who is:

- **Spouse.** The legally recognized spouse of a Participant, provided that a spouse that is legally separated or divorced from the Participant shall not be a Dependent, except for purposes of COBRA Continuation Coverage.

- **Child.** A child up to the end of the Plan Year when such child attains age 26, who is:
  - A natural child;
  - A legally adopted child, which shall be defined as a child adopted or placed for adoption with the Participant or the Participant's spouse. The child's placement for adoption ends upon the termination of the legal obligation;
  - A stepchild;
  - A child of a Participant required to be covered in accordance with applicable requirements of any Qualified Medical Child Support Order as defined by ERISA Section 609; or
  - A child with proof of legal guardianship for whom the Participant or the Participant's spouse is the court-appointed legal guardian.
- **Disabled Child.** A child, as defined above, regardless of age, who is incapable of self-sustaining employment due to a severe physical or mental condition that is expected to last indefinitely and who is dependent on a Participant or a Participant's Spouse for support and maintenance. If written proof of such incapacity and dependency satisfactory to the Plan is furnished to and approved by the Plan within thirty-one (31) days after the date the Disabled Child's coverage would otherwise terminate due to attaining age 26, the Disabled Child will remain a Covered Dependent and coverage will continue beyond the date the Disabled Child attains age 26, provided that the child continues to qualify as a Disabled Child and a Dependent. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan. A Disabled Child who terminates his/her coverage under the Plan will not be able to re-enroll unless the Disabled Child qualifies as a Special Enrollee and provides the required documentation to the Plan.
  - **Requirements for Initial or Special Enrollment of Disabled Child.** A Disabled Child may be enrolled in the Plan after attaining age 26, due to an initial or special enrollment, provided that within thirty-one (31) days of the date of hire of the Employee or within the 31-day special enrollment period, the following are furnished to and approved by the Plan:
    - Satisfactory written proof that such incapacity and dependency existed as of the date the Disabled Child attained age 26; and
    - Satisfactory written proof that the Disabled Child was covered under a major medical insurance plan (such as coverage through the Marketplace, an individual health insurance plan, or other group health plan coverage) immediately prior to the date of hire of the Employee or special enrollment period and did not experience a break in coverage of more than sixty (60) days.

  The Disabled Child will remain a Covered Dependent provided that the child continues to qualify as a Disabled Child and a Dependent. The Plan may require, at reasonable intervals, subsequent proof of incapacity and dependency satisfactory to the Plan.
- **Dependent Limitations.** In addition to the above limitations, Dependent does not include:
  - The spouse if on active duty in the Armed Forces of any country, unless such spouse is considered a TRICARE eligible employee, as defined under 10 U.S.C. § 1086;
  - A grandchild of the Participant or the Participant's Spouse, unless either is named the legal guardian of the child.

For purposes of coverage under this Plan, if both parents are Participants, a Dependent shall only be covered as a Dependent under this Plan by one parent.

Disability shall mean any congenital or acquired physical or mental Illness, defect or characteristic preventing or restricting an individual from participating in normal life, or limiting the individual's capacity to work. Such Disability must be certified by a Doctor.

Doctor shall mean a properly licensed person holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), or Doctor of Dental Surgery (D.D.S.).

Durable Medical Equipment shall mean equipment prescribed by a Doctor, which meets all of the following requirements:

- Is Medically Necessary;
- Is primarily and customarily used to serve a medical purpose;
- Is designed for prolonged and repeated use;
- Is for a specific therapeutic purpose in the treatment of an Illness or Injury;
- Would have been covered if provided in a Hospital; and
- Is appropriate for use in the home.

Effective Date shall mean the first day of coverage under this Plan as set forth in the Enrollment and Contributions for Participants and Dependents Section.

Eligible Retiree shall mean each Employee who is a Participant in the Plan during the 3 month period immediately prior to retirement from a Member, was Actively at Work on the day prior to retirement, meets both a minimum age of 55 years and a minimum service of 10 years of continuous service as an Employee with a Member, and the sum of such Employee's age and years of service is at least 70.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would place the individual's health in serious jeopardy, or seriously impair bodily functions, bodily organs, or parts.

Emergency Services or Emergency means, with respect to an Emergency Medical Condition:

- A medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under section 1867 of such Act to Stabilize the patient.

Employee shall mean:

- An Employee regularly scheduled to work at a position for a minimum of 75% of a full time Employee load as defined by the Member **and** shall not be less than 30 hours per week or 1560 hours per year;
- A faculty member teaching a minimum 75% of a full time teaching load, or equivalent, during the academic year with a Member;

  (For purposes of this calculation, Adjunct Faculty will be calculated with (a) 2.25 hours of service per week for each hour of teaching or classroom time, which represents a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of

examinations or papers, and, separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform, such as required office hours or required attendance at faculty meetings. The Member colleges may also use an alternate reasonable method that can be considered consistent with the above method, to calculate an Adjunct Faculty's hours of service.)

- An Employee that participates in either a "phased retirement" or "flexible retirement" program as defined by the employing Member institution;
- An Employee on an Approved Leave of Absence;
- An Employee on an Approved Sabbatical; or
- An Employee on an Approved Disability Leave.

The term **Employee** shall not include

- Leased employees;
- Collectively bargained employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals;
- Temporary employees;
- A member of the Member's board of directors, an owner, partner or officer unless engaged in the conduct of the business on a full time basis;
- An independent contractor or consultant who is paid on other than a regular wage or salary by the Member; or
- A student employee that is not paid or who is not entitled to pay or who is engaged in a federal work study program or similar program of a state or a political subdivision of a state.

Employer shall have the same meaning as Member, below.

ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

Experimental Procedure shall mean any service or supply that is judged to be experimental or investigative at the Plan's sole discretion. Services which do not meet each of the following criteria will be excluded from coverage as experimental or investigative:

- Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.
    - This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
        - the following three standard reference compendia defined below:
            - The U.S. Pharmacopoeia Dispensing Information
            - The American Medical Association Drug Evaluations
            - The American Hospital Formulary Service Drug Information
        - In substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for

scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

- In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

- There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.
- The available scientific evidence must show a good effect on health outcomes outside a research setting.
- The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered experimental or investigative.

Extended Care Facility shall mean an institution which:

- Is duly licensed as an Extended Care Facility, convalescent facility, or Skilled Nursing Facility and operates in accordance with governing laws and regulations;
- Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;
- Is staffed with a Doctor or Registered Nurse on duty 24 hours a day;
- Operates in accordance with medical policies, whereby such policies are supervised and established by a Doctor other than the patient's own Doctor;
- Regularly maintains a daily medical record for each patient;
- Is not, other than incidentally, a place for the aged, a place for individuals addicted to drugs or alcohol, or a place for Custodial Care; and
- Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

Family shall mean a Participant and covered Dependents.

Generic Drugs are simply copies of brand-name drugs. Brand-name and generic drugs have the same active ingredients, strength and dose. And the FDA requires that generic drugs meet the same high standards for purity, quality, safety and strength.

Genetic Information shall mean with respect to an individual, information about such individual's genetic tests, the genetic tests of Family members of such individual, and the manifestation of a disease or disorder in Family members of such individuals.

High Dose is a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

Home Health Care Services shall mean the following care provided to the Covered Person at the Covered Person's home or a Home Health Care Agency on recommendation of a Doctor:

- Intermittent care by a:
  - Registered Nurse (R.N.);
  - Licensed Practical Nurse (L.P.N.);
  - Home Health Aide;
  - Occupational and Physical Therapist;
  - Licensed Vocational Nurse (L.V.N.);
  - Physical Therapist Assistant (P.T.A.); or
  - Certified Occupational Therapist Assistant (C.O.T.A.).
- Private duty nursing services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
- Social work; and
- Nutrition services, including special meals.

Home Health Care Agency shall mean any of the following:

- A Home Health Care Agency licensed by the jurisdiction in which it is located;
- A Home Health Agency as defined by the Social Security Administration; or
- An organization licensed in the jurisdiction in which it is located which is an appropriate provider of Home Health Services, and which meets the following requirements:
  - Has a full time administrator;
  - Keeps written medical records; and
  - Has at least one Registered Nurse (R.N.) on staff, or the services of an R.N. available.

Hospice shall mean a public agency or a private organization which provides care and services for Terminally Ill persons and their families. Such agency or organization must be qualified to receive Medicare payments, or satisfy the following requirements:

- Provides and has available 24 hours per day:
  - Palliative and supportive care for Terminally Ill persons;
  - Services which encompass the physical, psychological and spiritual needs of Terminally Ill persons and their Families; and
  - Acute Inpatient Care, Outpatient Care, and Home Health Care. Care and counseling must be furnished directly by, or under the arrangement of such agency or organization;
- Has a medical director who is a Doctor;
- Has an interdisciplinary team to coordinate care and services, which includes at least one Doctor, one R.N. and one social worker; and
- Is licensed or accredited as a Hospice, if the laws of the jurisdiction in which it is located allow for the licensing or accreditation of Hospices.

Hospice Care shall mean care rendered by a Hospice in response to the special physical, psychological and spiritual needs of Terminally Ill Covered Persons and/or their Family members.

Hospital shall mean an institution which makes charges and is engaged primarily in providing Medical Care to sick and injured persons on an Inpatient basis at the patient's expense which fully meets all the requirements set forth below:

- Operates in accordance with the law of the jurisdiction in which it is located pertaining to institutions identified as Hospitals; as well as, primarily engages in providing Medical Care of injured and sick persons by or under the supervision of a staff of Doctors or surgeons for compensation from its patients on an Inpatient basis. It continuously provides 24 hour nursing services by Registered Nurses; maintains facilities on the premises for major operative surgery. A Hospital is not, (other than incidentally) a nursing home, a place for rest, a place for the aged, a place for the mentally ill or emotionally disturbed, or a place for the treatment of Substance Use Disorders.
- Accredited by the Joint Commission of Accreditation of Hospitals ("JCAH") or is recognized by the American Hospital Association ("AHA") and is qualified to receive payments under the Medicare program.
- A psychiatric Hospital, as defined by Medicare, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare.

Illness shall include disease, mental, emotional, or nervous disorders, and pregnancy.

Incurred Charges shall mean charges for services or supplies that are actually received. A charge shall be considered an Incurred Charge on the date the supplies or services are actually received.

Injury shall mean bodily Injury, including pregnancy following an act of rape or incest.

In-Network shall mean the services or supplies provided by a Participating Provider, or authorized by any of the VPC Benefits Consortium's contracted managed care Networks.

Inpatient shall mean a registered bed patient in a Hospital or Other Facility Provider and for whom a room and board charge is made. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Inpatient Care shall mean Medical Care provided to an Inpatient.

Maintenance Prescription Drugs are those You take on a regular, recurring basis to treat or control a chronic Illness such as heart disease, high blood pressure, epilepsy, or diabetes.

Masticatory Dysfunction/Malocclusion means:

- Anteroposterior discrepancies of greater than 2 standard deviations of published norms defined as either of the following:
    - Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a value less than or equal to zero (norm 2mm). (Note: Overjet up to 5mm may be treatable with routine orthodontic therapy); or
    - Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm);
- Vertical discrepancies:
    - Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks;

- Open bite:
  - No vertical overlap of anterior teeth;
  - Unilateral or bilateral posterior open bite greater than 2mm.
- Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch;
- Supra-eruption of a dentoalveolar segment due to lack of occlusion;

- Transverse Discrepancies:
  - Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms;
  - Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth;
- Asymmetries:
  - Anteroposterior, transverse or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry.

    When the condition involves treatment of malocclusion, both of the following must be present:
    - Completion of skeletal growth with long bone x-ray or serial cephalometrics showing no change in facial bone relationships over the last three to six month period (Class II malocclusions do not require this documentation); and
    - Documentation of malocclusion with either intra-oral casts (if applicable) bilateral, lateral x-rays, cephalometric radiograph with measurements, panoramic radiograph or tomograms.

    When the condition involves treatment of skeletal deformity, the deformity must be documented either by CT, MRI or x-ray.

Maximum Benefit shall mean the maximum amount to be paid by the Plan on behalf of a Covered Person for Covered Services, which are incurred while such Covered Person is covered under the Plan.

Medical Care shall mean professional services rendered by a Doctor or Other Professional Provider for the treatment of an Illness or Injury.

Medically Necessary or Medical Necessity shall mean the drug, device, procedure, service, treatment or supplies which are required to identify or treat a Covered Person's Illness or Injury and which are:

- Commonly and customarily recognized by the medical profession as appropriate care consistent with the symptom or diagnosis and treatment of the Illness or Injury;
- Appropriate with regard to standards of sound medical practice;
- Not primarily Custodial Care;
- Services that could not have been omitted without adversely affecting the Covered Person's condition or the quality of Medical Care rendered;
- Not solely for the convenience of a Covered Person, Doctor, Other Professional Provider, Hospital or Other Facility Provider;

- The most appropriate supply or level of service which can be safely provided to Covered Person, or for an Inpatient, as the Covered Person's medical symptoms or condition require, and that the services cannot be safely provided to the Covered Person's as an Outpatient; and
- Not including unnecessary repeated tests.

Note: Although a Doctor or Other Professional Provider may have prescribed treatment, such treatment may not be considered Medically Necessary within this definition.
Right to Choose: The Plan does not limit a Covered Person's right to choose his or her own Medical Care**.** If a medical expense is not a Covered Expense, or is subject to a Limitation or Exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if applicable, if the provider is Out-of-Network, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Coinsurance level with the Covered Person being responsible for a larger percentage of the total medical expense.

Medicare shall mean Title XVIII of the United States Social Security Act, as amended, and the Regulations promulgated thereunder.

Member shall mean the independently governed and operated institutions of higher education in the Commonwealth of Virginia who are Members of the Council of Independent Colleges in Virginia, operating as Virginia Private Colleges, and who are approved for membership as set forth in the Articles of Incorporation and Bylaws of the VPC Benefits Consortium. The term Member shall also mean any affiliated foundation or other entity associated with such institutions, and any other entity adopting the Plan with the approval of its governing body and the VPC Benefits Consortium as set forth in its Articles of Association. If a Member merges or is otherwise consolidated with any affiliate, the successor shall, as to the group of Members covered by the Plan immediately before such merger or consolidation, be the Member as defined hereunder, unless the VPC Benefits Consortium specifies to the contrary. In the case of any other merger or consolidation, the successor shall not be the Member except to the extent that it acts, with the approval of the VPC Benefits Consortium, to adopt the Plan.

Mental Health Conditions shall mean a condition that causes impairment of an individual's normal cognitive, emotional, or behavioral functioning, caused by social, psychological, biochemical, genetic, or other factors, that can be treated with psychiatric medication, psychotherapy, lifestyle adjustments and other supportive measures. Including, without limiting the foregoing:

- Anxiety Disorders;
- Childhood Disorders;
- Eating Disorders;
- Mood Disorders;
- Cognitive Disorders (Delirium, Dementia, Amnestic Disorders);
- Schizophrenia & Other Psychotic Disorders; and/or
- Personality Disorders.

Mental Health Conditions shall not include learning disabilities, behavioral problems or attention-deficit disorder.

Morbid Obesity shall mean a body mass index (BMI) of 40.0 or greater, where BMI equals weight in kilograms divided by height in meters squared.

Network shall mean any preferred provider or managed care Network under contract with the VPC Benefits Consortium to provide or arrange to provide services or supplies to Covered Persons.

Other Facility Provider shall mean any of the following: Ambulatory Care Facility, Substance Use Disorder Treatment Facility, free-standing dialysis facility, Outpatient psychiatric facility, psychiatric Day Treatment facility, psychiatric Hospital, Hospice, Extended Care Facility, or rehabilitation facility, which is licensed as such in the jurisdiction in which it is located.

Out-of-Network shall mean Drugs, devices, procedures, services, treatments or supplies which are not provided by a Participating Provider or approved by any of VPC Benefits Consortium's contracted managed care Networks.

Out-of-Pocket (or Out-of-Pocket Amounts/Costs/Expenses) shall mean any amount of Deductible and Coinsurance that the Covered Person or Family pays for a Covered Expense during the Calendar Year as specified in the associated SBCs.

Out-of-Pocket Maximum shall mean the maximum amount of Deductible and Coinsurance during any Calendar Year that the Covered Person or Family shall pay before the Plan shall pay 100% of Covered Services for that Calendar Year. Hospital Admission Copayments apply to the Out-of-Pocket Maximum. *Refer to "out-of-pocket limit" in the associated SBC.

Outpatient shall mean a Covered Person who receives Drugs, devices, procedures, services, treatments or supplies while not confined as an Inpatient.

Outpatient Care shall mean Medical Care provided to a Covered Person while the Covered Person is an Outpatient.

Outpatient Mental Health Services are for the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

Outpatient Surgery shall mean surgical services provided to the Covered Person while the Covered Person is an Outpatient.

Part Time Employee shall mean:

- An Employee regularly scheduled to work at a position for a minimum of 1000 hours per year or equivalent, but less than the required number of hours to meet the definition of an Employee; or
- A faculty member teaching at least 50% of a full teaching load, or equivalent, but less than the required teaching load to meet the definition of an Employee, as determined by the Member Institution.

  (For purposes of this calculation, Adjunct Faculty will be calculated with (a) 2.25 hours of service per week for each hour of teaching or classroom time, which represents a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers, and, separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform, such as required office hours or required attendance at faculty meetings. The Member colleges may also use an alternate reasonable method that can be considered consistent with the above method, to calculate an Adjunct Faculty's hours of service.)

The term Part Time Employee shall not include:

- Leased Employees;
- Collectively bargained Employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals;

- Temporary Employees;
- A member of the Member's board of directors, an owner, partner or officer unless engaged in the conduct of the business on a full time basis;
- An independent contractor or consultant who is paid on other than a regular wage or salary by the Member; or
- A student Employee that is not paid or who is not entitled to pay or who is engaged in a federal work study program or similar program of a state or a political subdivision of a state.

A Part Time Employee must properly enroll in the Plan, continuously meet the requirements for eligibility and pay the required contributions on a timely basis, as described in the Enrollment Contributions Section.

Participant shall mean an Employee, Part Time Employee, or Eligible Retiree who meets the requirements for eligibility and properly enrolls in the Plan and continuously meets the requirements for eligibility.

Participating Doctor shall mean a duly licensed Doctor under contract with any of the VPC Benefits Consortium's contracted managed care Networks.

Participating Provider shall mean any Hospital, Doctor, pharmacy, Other Professional Provider, Other Facility Provider or other entity under contract with the VPC Benefits Consortium's contracted managed care Networks. The participation status may change from time to time. Refer to the provider directory or contact Member Services for a listing of the Participating Providers.

Physician shall have the same meaning as Doctor, above.

Plan, The Plan or This Plan shall mean Virginia Private Colleges Benefits Consortium, Inc. Health Plan.

Plan Administrator shall mean Tim Klopfenstein, Executive Director of the VPC Benefits Consortium.

Plan Year shall mean January 1st through December 31st of each year.

Post-Service Claims shall mean all claims other than Pre-Service, Urgent Care or Concurrent Care Claims. Post-Service Claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where the Covered Person requests authorization in advance.

Pre-Service Claims shall mean claims for a service that require the Covered Person to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If the Covered Person calls to receive authorization for a service when authorization in advance is not required, the claim will be considered a Post-Service Claim.

Preauthorization or Preauthorized shall mean the preapproval of a Covered Expense for all services specified by the Plan as requiring preapproval.

Prescription Drugs shall mean drugs or medicines obtainable only upon a Doctor's written prescription, including any medication compounded by the pharmacist that contains a prescription legend drug, insulin and insulin needles and syringes.

Preventive Care shall have the meaning set forth in Section 7.

Primary Care Physician shall mean a Doctor responsible for managing and coordinating the full scope of a Covered Person's Medical Care, including but not limited to performing routine evaluations and treatment, ordering laboratory tests and x-ray examinations, prescribing necessary medications and arranging for a Covered Person's Hospitalization or other services when appropriate. Primary Medical Care includes these medical specialties: Internal Medicine (general), Pediatrics, Family Practice and Obstetrics/Gynecology (OB/GYN).

Professional Provider (or Other Professional Provider) shall mean the following persons or practitioners, including Doctors, acting within the scope of such provider's license, which is certified and licensed in the jurisdiction in which the services are provided:

- Audiologist;
- Anesthesiologist;
- Certified Nurse Practitioner;
- Clinical Social Worker;
- Dentist;
- Emergency medical technician;
- Independent laboratory technician;
- Licensed Practical Nurse;
- Nurse Midwife;
- Occupational Nurse;
- Occupational Therapist;
- Pharmacist;
- Physical Therapist;
- Doctor Assistants;
- Registered Nurse;
- Respiratory Therapist; and/or
- Speech - Language Pathologist or Audiologist.

Qualified Beneficiary is the Participant or a covered Dependent who is eligible to continue coverage under COBRA.

Reconstructive Surgery Following Mastectomy shall mean surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes all stages of reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive breast surgery shall also include augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

Service Area is the geographic area within which Covered Services are available.

Skilled Nursing Care shall mean service provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), provided the care is Medically Necessary and the treating Doctor has prescribed such care.

Skilled Nursing Facility shall mean an institution which:

- Is duly licensed as an Extended Care Facility or convalescent facility, and operates in accordance with governing laws and regulations;
- Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;
- Is staffed with a Doctor or Registered Nurse on duty 24 hours a day;

- Operates in accordance with medical policies supervised and established by a Doctor other than the patient's own Doctor;
- Regularly maintains a daily medical record for each patient;
- Is not, other than incidentally, a place for the aged, a Substance Use Disorder Treatment Facility, or a place for Custodial Care; and
- Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

Special Enrollee shall mean an Employee or Dependent who is entitled to and who requests Special Enrollment as described in the Enrollment and Contributions Section.

Specialist shall mean Doctors who generally specializes in one field of medicine (i.e. Cardiologist, Neurologist).

Spinal Manipulation Treatment shall mean office visits or treatment, which involve manipulation (with or without the application of treatment such as heat, water or cold therapy, diathermy or ultrasound) of the spinal skeletal system and surrounding tissues to allow free movement of joints, alignment of bones, or enhancement of nerve functions.

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, or, with respect to an Emergency Medical Condition, to deliver (including the placenta).

Substance Use Disorder shall mean an addiction to either drugs and/or alcohol.

Substance Use Disorder Treatment Facility shall mean a facility, other than an acute care Hospital, established to care and treat those who need Inpatient Medical Care due to alcoholism or drug abuse. The institution must have permanent facilities on the premises for Inpatient Medical Care. The institution must be licensed, registered or approved by the appropriate authority of the jurisdiction in which it is located or it must be accredited by the American Hospital Association. It must keep daily medical records on all patients. A Substance Use Disorder Treatment Facility shall not include an institution, or part of one, used mainly for rest care, nursing care, care of the aged or Custodial Care.

Telemedicine shall mean the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder Services ("TMJ") shall mean services rendered for the disorder of the jaw and craniomandibular joint.

Terminal Illness or Terminally Ill shall mean a life expectancy of 6 months or less.

Termination of Employment or Terminates Employment shall mean the severance of an Employee's employment relationship with a Member and all other affiliates, or the expiration of an Approved Leave of Absence, Approved Sabbatical or leave mandated by the Family and Medical Leave Act from a Member without the Employee returning to the employment of such Member or any affiliate.

Tier 1 Drugs (formerly "Generics") have the lowest cost share. These (usually generic) drugs offer the best value compared to other drugs that treat the same conditions.

Tier 2 Drugs (formerly "Preferred Brands") have a higher cost share than Tier 1 drugs. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some may be generic drugs that may cost more because they are newer to the market.

Tier 3 Drugs ("formerly "Non-Preferred Brands") have a higher cost share than Tier 2 drugs. They often include non-preferred brand and generic drugs. They may cost more than drugs on lower tiers used to treat the same condition. Tier 3 may also include drugs recently approved by the FDA.

Tier 4 drugs (formerly "Specialty") have a higher cost share than Tier 3 drugs and usually include preferred specialty brand and generic drugs. They may cost more than drugs on lower tiers used to treat the same condition. Tier 4 may also include drugs recently approved by the FDA or specialty drugs used to treat serious, long-term health conditions and that may need special handling.

Urgent Care Claims shall mean claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's Physician, would subject the patient to severe pain. The Plan will defer to the patient's Physician as to whether a claim involves urgent care.

Waiting Period shall mean the period that must pass under this Plan before an Employee or Dependent is eligible to enroll in the Plan (or other health plan as the case may be). Notwithstanding the foregoing, if an Employee or Dependent enrolls as a Special Enrollee on a Special Enrollment Date, any period before such Special Enrollment is not a Waiting Period.

You or Your shall mean the Participant.

Appendix A
Summaries of Benefits and Coverage for Plans 2-7 and 12

Below is a comprehensive list of Summaries and Benefits and Coverage associated with this Plan Document and Summary Plan Description. See the Summary of Benefits and Coverage for Your Member college for additional Plan information.

- Plan 2 PPO Summary of Benefits and Coverage
- Plan 3 PPO Summary of Benefits and Coverage
- Plan 4 PPO Summary of Benefits and Coverage
- Plan 5 PPO Summary of Benefits and Coverage
- Plan 6 PPO & HRA Non-Embedded Summary of Benefits and Coverage
- Plan 6 PPO & HSA Non-Embedded Summary of Benefits and Coverage
- Plan 7 PPO & HRA (Embedded Deductible) Summary of Benefits and Coverage
- Plan 7 PPO & HSA (Embedded Deductible) Summary of Benefits and Coverage
- Plan 12 PPO & HSA (Embedded Deductible) Summary of Benefits and Coverage

If You have any questions about which plans are available to You at Your Member college, please contact Your Human Resources Department.

Appendix B
Summary of Benefits for Plans 2-7 and 12

Below is a comprehensive list of Summaries and Benefits associated with this Plan Document and Summary Plan Description. See the Summary of Benefits for Your Member college for additional Plan information.

- Plan 2 PPO Summary of Benefits
- Plan 3 PPO Summary of Benefits
- Plan 4 PPO Summary of Benefits
- Plan 5 PPO Summary of Benefits
- Plan 6 PPO & HRA Non-Embedded Summary of Benefits
- Plan 6 PPO & HSA Non-Embedded Summary of Benefits
- Plan 7 PPO & HRA (Embedded Deductible) Summary of Benefits
- Plan 7 PPO & HSA (Embedded Deductible) Summary of Benefits
- Plan 12 PPO & HSA (Embedded Deductible) Summary of Benefits

If You have any questions about which plans are available to You at Your Member college, please contact Your Human Resources Department.