Summary Plan Description for Sentry Insurance Company

Sentry Retiree Medical Plan – Plus Option

Effective January 1, 2024

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Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece en el reverso de su Tarjeta de Identificación.

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

The Sentry Retiree Medical Plan – Plus Option (the "Plan") is a self-funded comprehensive health benefit plan for eligible Retirees and their Dependents and is governed by the Employee Retirement Income Security Act of 1974 (ERISA) and the Department of Labor (DOL). The Plan is administered in accordance with its Plan Document. The Plan Administrator of the Plan retains discretionary authority to construe, interpret, and apply the terms of the Plan. The Plan Administrator also has the sole discretion to determine eligibility for the Plan and Plan benefits. This is not an insured benefit Plan. The benefits described in this Summary Plan Description (SPD) or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. The following provides information on the Plan in general and is the Plan’s SPD. Please read this SPD carefully. It summarizes the benefits and features of the Plan. However, the Plan is governed by a formal Plan Document. If there are inconsistencies between this document and the formal Plan Document, the Plan Document shall control and rule. Please consult the formal Plan Document to determine Your full rights, as well as the rights of the Employer. You may obtain copies of the formal Plan from Your Human Resources representative or by contacting the Plan Administrator.

This SPD is intended as a brief description of the Sentry Retiree Medical Plan – Plus Option and provides You with a description of Your benefits while You are enrolled under the health care plan (the “Plan”) offered by Your Employer. You should read this SPD carefully to familiarize Yourself with the Plan’s main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this SPD, please contact Your Employer or call the Claims Administrator’s Member Service department. The Employer maintains a HIPAA Privacy Statement on behalf of the Group Health Plans. You may request a paper copy of this statement by contacting Human Resources.

The Plan Sponsor may change the benefits described in this SPD and the Member will be informed of such changes as required by law. This SPD shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

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

For Pre-Medicare Members, this is a Preferred Provider Organization (PPO) plan except residents of Wisconsin; Members residing in WI are part of a Point of Service (POS) plan and must use the appropriate POS In-Network Provider in their state to receive In-Network benefits. If You are a Member in a state outside of Wisconsin that participates in a Select Network arrangement, please call the Member Service number on Your Identification Card to locate participating Providers.

Anthem Blue Cross and Blue Shield, or “Anthem” and Express Scripts, have been designated by Your Employer to provide administrative services for the Employer, such as claims processing, care management, and other services, and to arrange for a Network of health care Providers whose medical services are covered by the Plan. Anthem and Express Scripts provide administrative claims payment services only and do not assume any financial risk or obligation with respect to claims. Your Employer has agreed to be subject to the terms and conditions of Anthem’s Provider agreements which may include precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this Plan.

Participants are expected to fully cooperate and comply with reasonable plan requests, and failure to do so may result in a loss of coverage or benefits, or other outcomes determined appropriate by the plan.

The Plan is a retiree only plan and not subject to provisions of the Patient Protection and Affordable Care Act (PPACA) or the Consolidated Appropriations Act of 2021.

VERIFICATION OF BENEFITS

Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Member Service with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 8:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is not a guarantee of payment. Call the Member Service number on your Identification Card or see the section titled Health Care Management for Precertification rules.

IDENTITY PROTECTION SERVICES

If you are enrolled in an Anthem medical plan you automatically receive a basic level of Identity Repair Services and can voluntarily enroll in Credit and Identity Theft Monitoring Services, at no cost to you. To learn more about these services, please visit https://anthemcares.allclearid.com/.

Plan information

Member rights and responsibilities

As a Member You have rights and responsibilities when receiving healthcare. As Your healthcare partner, we want to make sure Your rights are respected, while providing Your health benefits. That means giving You access to our network of doctors and healthcare professionals, who help You make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your doctors and other healthcare professionals about healthcare options and treatment needed for Your condition no matter what the cost or whether it is covered under Your Plan.
- Work with Your doctors and other healthcare professionals to make choices about Your health care.
- Be treated with respect and dignity.
- Expect us to keep Your personal health information private by following our privacy policies, and state and Federal laws.
- Receive information You need to fully engage with Your health Plan, and also share Your feedback. This includes:
  - Our company and services.
  - Our network of doctors and other healthcare professionals.
  - Your rights and responsibilities.
  - The way Your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care You receive.
  - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care You may receive in the future. This includes asking Your doctors and other healthcare professionals to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a doctor about the cause of Your illness, Your treatment, and what may result from it. You can ask for help if You do not understand this information.
- Get help at any time, by calling the Member Services number located on the back of Your Identification Card or by visiting www.anthem.com.

You have the responsibility to:

- Read all information about Your benefits and ask for help if You have questions.
- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if Your Plan requires it.
- Treat all health care professionals and staff with respect.
- Keep all scheduled appointments. Call Your doctor's office if You may be late or need to cancel.
- Understand Your health challenges as well as You can and work with Your doctors and other healthcare professionals to create and agreed upon treatment Plan.
- Inform Your doctors and other healthcare professionals if You don't understand the type of care and Your actions that they're recommending.
- Follow the treatment plan that You have agreed upon with Your doctors and other healthcare professionals.
- Share the information needed with us, Your doctors and other healthcare professionals to help You get the best possible care. This may include information about other health insurance benefits You have in addition to Your coverage with us.
- Inform Member Services if You have any changes to Your name, address, or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact us, please go to www.anthem.com and select Contact Us, or call the Member Services number on Your Identification Card.

We are here to provide high quality benefits and service to our Members. Benefits and coverage for services given under the Plan are overseen by Your Certificate of Coverage, Member Handbook, or **Schedule of Benefits**-and not by this **Member Rights and Responsibilities** statement.

Pre-Medicare eligibility

COVERAGE FOR THE RETIREE

You are eligible for this Plan as a pre-Medicare Retiree at the time of Your retirement if You are an Employee who retires from the Employer, who is:

1. Hired prior to January 1, 2010; or
2. Considered an Employee or Retiree prior to January 1, 2010 and is rehired after January 1, 2010 within 180 days after his or her employment termination date.

And, in addition to 1 or 2, is:

3. A retiree after December 31, 2005 and at least age 55 with at least 10 years of service at his or her retirement date;
4. A retiree after December 31, 2005 and at least age 65;
5. A retiree prior to February 1, 1993 who met the age and/or service requirements then in effect to be a retiree; or
6. A retiree after January 31, 1993 but prior to January 1, 2006 who met the age and/or service requirements then in effect to be a retiree.

IMPORTANT INFORMATION ABOUT MEDICARE ELIGIBILITY

Effective January 1, 2015, the Sentry Retiree Medical Plan – Plus Option is limited to Retirees and eligible covered Dependents of Retirees:

1. Who are not eligible for Medicare, or
2. If the Retiree retired prior to January 1, 2000 and have reached Medicare eligibility on or before January 1, 2015 (see the Post-Medicare Eligibility section of this Summary Plan Description), and
3. Who have not participated in the RRA option.

If You are Medicare-eligible at the time of Your retirement or become eligible for Medicare on or after January 1, 2015, the Sentry Retiree Medical Plan – Plus Option is no longer available. This is the case whether or not You actually enroll in Medicare. Refer to the Sentry Retiree Medical Plan – Retiree Reimbursement Arrangement (RRA) option.

Note: If You're under age 65 and only qualify for Medicare Part A, You may be permitted enrollment in the Plan. Once You become eligible for Medicare Part B, You are no longer eligible for the Plan as of the Medicare Part B effective date. Contact Sentry Human Resources for details.

COVERAGE FOR THE RETIREE'S DEPENDENTS

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

If You have one or more eligible Dependents at the time of retirement, You will be eligible for "Retiree plus family" coverage. You may enroll any eligible Dependents (spouse and children) who were part of Your family on the date of retirement.

If the wrong birth date of a child is entered on an application, the child has no coverage for the period for which he or she is not eligible. Any claims paid during the dependent's ineligible period will be the responsibility of the Member.

Eligible Dependents include:

- A Retiree's legally married spouse at the later of the time of retirement or December 31, 2013 who is not eligible for Medicare. A domestic partner, divorced spouse, spouse by common law, or legally separated spouse is not considered a Dependent and will not be covered under this Plan unless otherwise required by state law not pre-empted by the Employee Retirement Income Security Act (ERISA).
- A Retiree's unmarried child(ren) whom the Retiree or the Retiree's covered Spouse is not eligible for Medicare and the Retiree is eligible to claim as a Dependent on his or her taxes for the plan year of coverage. To be claimed for the year of coverage under this Plan the eligible child must satisfy the Internal Revenue Code Section 152 definition of dependent. An eligible child must:
  - Be a natural child, a stepchild, a foster child, a legally adopted child, a child placed with the Retiree for the purposes of legal adoption, a child of the Retiree's spouse, or a child of the Retiree's unmarried

Dependent child who is covered under this Plan and has not attained the age of 19 or age 24, if a full-time student;
  - Have the same principal residence as the Retiree, a parent or legal guardian for more than one-half of the taxable year. Exception is granted for temporary absences such as illness, education, business, vacation, or military service;
  - Not have attained the age of 19 or age 24, if a full-time student; and
  - Not have provided more than one-half of his or her own support for the calendar year.
- A Retiree's unmarried child, regardless of age, if mentally or physically disabled, as long as the child was otherwise covered under this Plan as a Dependent and the disability occurred prior to the limiting age.

Effective January 1, 2014 an enrolled Dependent child is no longer eligible if the Retiree and the covered Spouse, if applicable, are both eligible for Medicare.

THE RETIREE'S SURVIVING SPOUSE AND SURVIVING DEPENDENTS

If You die while covered under the Plan, Your spouse and Dependents who were covered by the Plan at the time of Your death will be given the option of either 1) electing COBRA and continuing coverage under the Plan pursuant to COBRA for up to 36 months, or 2) remaining covered under the plan's surviving spouse and dependent coverage provisions as described directly below and in When Coverage Terminates.

Under the Plan's surviving spouse and dependent coverage provisions (which is only available if COBRA is not elected), coverage will be provided as follows:

- If the Retiree retired before January 1, 2003 and subsequently dies, then Employer-paid coverage continues for Your spouse and Dependent children until the January 1 following the first anniversary of the Retiree's death. After the Employer-paid coverage period ceases, Your spouse and Dependent children may remain on the plan paying the full premium for the remainder of 36 months. If the required premium is not paid, coverage will be canceled and may not be reinstated. With respect to Dependents, coverage will end on the last day of the month in which the Dependent ceases to be a Dependent under the Plan. See When Coverage Terminates for further details.
- If the Retiree retired on or after January 1, 2003 and subsequently dies, then Employer-paid coverage continues for Your spouse and Dependent children until the 1st of the month following the date of death plus 18 months. After the Employer-paid coverage period ceases, Your spouse and Dependent children may remain on the plan paying the full premium. If the required premium is not paid, coverage will be canceled and may not be reinstated. With respect to Dependents, coverage will end on the last day of the month in which the Dependent ceases to be a Dependent under the Plan. See When Coverage Terminates for further details.

Note that if Your enrolled spouse and/or Dependent children choose to elect COBRA (thus waiving coverage under the surviving spouse and Dependent children provision) they may be able to continue coverage under COBRA for up to a maximum of 36 months. Contact Human Resources for information on continuing coverage. See Continuation of Coverage for more information.

Post-Medicare eligibility

COVERAGE FOR THE RETIREE

Eligible Retirees and eligible Spouses include:

1. Hired prior to January 1, 2010; or
2. Considered an Employee or Retiree prior to January 1, 2010 and is rehired after January 1, 2010 within 180 days after his or her employment termination date.

In addition to 1 or 2, is:

3. A retiree after December 31, 2005 and at least age 55 with at least 10 years of service at his or her retirement date; or
4. A retiree after December 31, 2005 and at least age 65; or
5. A retiree prior to February 1, 1993 who met the age and/or service requirements then in effect to be a retiree; or
6. A retiree after January 31, 1993 but prior to January 1, 2006 who met the age and/or service requirements then in effect to be a retiree.

And

7. The Retiree retired prior to January 1, 2000 and has reached Medicare eligibility on or before January 1, 2015, and
8. The Retiree or eligible Spouse did not participate in the Sentry Retiree Medical Plan – RRA Option prior to or after January 1, 2015.

COVERAGE FOR THE RETIREE'S SPOUSE

If the Retiree is covered by this Plan, the Retiree may enroll his or her eligible Spouse. Covered Spouses are also called Members. If You have an eligible Spouse at the time of retirement, You will be eligible for "Retiree plus Spouse" coverage. You may enroll Your eligible Spouse who You were legally married to on the date of retirement. If You remarry after You retire, the new spouse will not be eligible for coverage.

ELIGIBLE DEPENDENTS

- A Retiree's legally married spouse at the later of the time of retirement or December 31, 2013. A domestic partner, divorced spouse, spouse by common law, or legally separated spouse is not considered a Dependent and will not be covered under this Plan unless otherwise required by state law not pre-empted by ERISA.

THE RETIREE'S SURVIVING SPOUSE

If You die while covered under the Plan, Your Spouse who was covered by the Plan at the time of Your death will be given the option of either 1) electing COBRA and continuing coverage under the Plan pursuant to COBRA for up to 36 months, or 2) remaining covered under the plan's surviving spouse and dependent coverage provisions as described directly below. Under the Plan's surviving spouse coverage provisions (which is only available if COBRA is not elected), coverage will be provided as follows:

- If the Retiree retired before January 1, 2003 and subsequently dies, then Employer-paid coverage continues for Your spouse until the January 1 following the first anniversary of the Retiree's death. After the Employer-paid coverage period ceases, Your spouse may remain on the plan paying the full premium for the remainder of 36 months. If the required premium is not paid, coverage will be canceled and may not be reinstated. See When Coverage Terminates for details.
- If the Retiree retired on or after January 1, 2003 and subsequently dies, then Employer-paid coverage continues for Your spouse until the 1st of the month following the date of death plus 18 months. After the Employer-paid coverage period ceases, Your spouse may remain on the plan paying the full premium. If the required premium is not paid, coverage will be canceled and may not be reinstated. See When Coverage Terminates for details.

Note that if Your enrolled Spouse chooses to elect COBRA (thus waiving coverage under the surviving spouse provision) they may be able to continue coverage under COBRA for up to a maximum of 36 months. Contact Human Resources for information on continuing coverage. See Continuation of Coverage for more information.

COVERAGE FOR THE RETIREE'S DEPENDENT CHILDREN

Dependent children of the Retiree are not eligible for coverage under the Plan. Effective January 1, 2014, an enrolled Dependent child is no longer eligible if the Retiree and the Covered Spouse, if applicable, are both eligible for Medicare.

Enrollment in the Plan

HOW TO ENROLL

You enroll by means that are acceptable by the Employer. If You want to enroll Your eligible Dependents, You enter the name of each Dependent You are enrolling and the Dependent's Social Security Number, date of birth, student status (if between age 19 and 23), disabled status (if age 19 or older), address, and Phone number.

INITIAL ENROLLEES

Initial Enrollees who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Eligible Dependents who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage if the Retiree or the Retiree's eligible spouse is not eligible for Medicare. You must complete enrollment for medical coverage by means that are acceptable by the Employer, specify whether You want coverage for Your Dependents (i.e., "Family" coverage), and pay any required contributions in order to be covered by the Plan. Upon enrollment, You and Your Dependents may be subject to any requirements or limitations placed on on-time and Late Enrollees.

Your eligible Dependents may be enrolled at the same time You enroll Yourself. If You acquire new Dependents, they may be enrolled in accordance with the open enrollment period and special enrollment period requirements listed below if the Retiree or the Retiree's eligible spouse is not eligible for Medicare. Once You are enrolled, You may not change or drop the coverage selected until the next open enrollment period, unless a Qualified Change in Status occurs. If a Qualified Change in Status occurs, You may be permitted to change Your coverage, enroll new Dependents, or drop Dependents during the special enrollment period.

INITIAL ENROLLMENT PERIOD

As long as You are eligible, You may enroll for coverage within 30 days of Your retirement date. You may also enroll eligible Dependents for coverage during this period.

If You enroll during Your initial enrollment period, Your coverage begins on the first day of the calendar month coinciding with or next following Your retirement date as long as You complete Your enrollment during Your 30-day enrollment period, and provided any required contributions are paid.

Pre-Medicare Qualified Retirees/Spouses

If You do not enroll during the initial enrollment period, You may only enroll later during an open enrollment period or, if a Qualified Change in Status occurs, during a special enrollment period. Upon becoming eligible for Medicare, You and/or Your spouse will have a one-time opportunity to enroll in a Plan option.

Medicare Eligible Qualified Retirees/Spouses

You have a one-time opportunity to enroll during the initial enrollment period. If You do not enroll during Your initial enrollment period, You will not have another opportunity to enroll again in the future.

LATE ENROLLEES

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

LATE ENROLLMENT

If You did not enroll in the Plan within 30 days of Your first eligibility date (as of Your retirement date) or if You discontinue enrollment in the Plan for any reason and then later want to enroll in medical coverage, You must meet any requirements placed upon Late Enrollees. If You decline enrollment for Yourself or Your Dependents (including Your spouse) in the Plan because of other health insurance or group health plan coverage, You may be able to enroll Yourself or Your Dependents in this Plan if You or Your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward Your or Your Dependents' other coverage). You must request enrollment within 30 days after Your other coverage ends (or after the employer stops contributing to the other coverage). If You are eligible for Medicare and You discontinue enrollment in the Plan at any time, You will not be eligible to re-enroll in the Plan in the future.

OPEN ENROLLMENT PERIOD

The Employer conducts an open enrollment period at least once per Plan Year. During this period, You may be eligible to make the following changes based on Your current enrollment status.

If You are currently enrolled in medical coverage, You may:
- Change Your coverage category
- Drop coverage for any Covered Member or coverage in its entirety; or
- Add coverage. Retirees/Spouses who are eligible for Medicare may only add coverage due to a Qualified Change in Status. See Special Enrollment Period below.

If You do not change Your medical coverage or coverage category, You will continue with the same coverage as You previously selected, unless notified otherwise.

If You are not currently enrolled in medical coverage and You are not eligible for Medicare, You may:
- Enroll in the Plan as a late enrollee.
- Enroll eligible Dependents as Late Enrollees.

If You enroll during an open enrollment period, Your coverage begins with the new Plan Year. Your application has to be received and approved during the open enrollment period. If You enroll in "Retiree plus spouse," "Retiree plus child(ren)," or "Family" coverage, Your covered Dependent's coverage begins with the new Plan Year. Your application for "Retiree plus spouse," "Retiree plus child(ren)," or "Family" coverage has to be received and approved during the open enrollment period. If You were previously eligible to participate under the Plan but did not enroll, You and Your Dependents, if applicable, will be considered as Late Enrollees.

SPECIAL ENROLLMENT PERIODS FOR PRE-MEDICARE RETIREES/SPOUSES

If a Retiree or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Retiree or Dependent must request Special Enrollment within 30 days of a qualifying event. If You enroll during a special enrollment period, Your coverage begins on the 1st of the month coinciding with or next following the Qualified Change in Status event (except for birth, placement for adoption, or legal adoption of a child, which is effective on the date of the Qualified Change in Status)—as long as You enroll during Your 30-day special enrollment period. If You do not complete a special enrollment during the 30-day period, You cannot enroll until the next open enrollment period unless You have another Qualified Change in Status event. If You enroll in "Retiree plus spouse," "Retiree plus child(ren)," or "Family" coverage during a special enrollment period, Your covered Dependent's coverage begins on the 1st of the month following or coinciding with the event date (except for birth, adoption, or placement for adoption, which is effective on the date of the Qualified Change in Status).

Special Enrollment is available for eligible individuals who:
- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important notes about Special Enrollment Period:
- Individuals enrolled during special enrollment periods are not Late Enrollees.
- If You were previously eligible to participate under the Plan but did not enroll, You and Your Dependents, if applicable, will be considered as Late Enrollees.
- Individuals or Dependents must request coverage within 30 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births or adoptions or placement for adoption. An unenrolled Member may enroll within 30 days of such a special qualifying event. The following Qualified Change in Status events are recognized by the Plan and may open a special enrollment period if they result in a Spouse or Dependent becoming newly eligible or losing coverage under the plan and if the Retiree or the Retiree's eligible spouse is not eligible for Medicare:
- Change in legal marital status due to death of a spouse, divorce, legal separation, or annulment.
- Change in number of Dependents due to birth, death, legal adoption, placement for legal adoption, or legal guardianship or custody.
- Change in employment status of a Retiree, participant, or spouse due to, termination or commencement of employment, commencement of or return from an unpaid leave of absence, Change in the work-site (where elected coverage is no longer available or where new coverage is now available that previously was not available), or change in employment status for You, Your spouse, or Your Dependent that affects his or her eligibility for coverage under the Plan.

- Change in a Dependent's eligibility due to an event that causes a Dependent to become eligible or ineligible under the Plan on account of marriage, age, student status, or any similar circumstances.
- A Covered Member becomes entitled to or loses coverage under Medicare (Part A or B of Title XVIII of the Social Security Act) or under Medicaid (Title XIX of the Social Security Act). Medicare or Medicaid entitlement will not include coverage consisting solely for distribution of pediatric vaccines.
- Costs charged to a Covered Member for a Sentry benefit option during the Plan Year significantly increase or decrease.
- Coverage offered to a Covered Member for a Sentry benefit option during the Plan Year is significantly curtailed.
- The Plan adds a new benefit option or significantly improves an existing benefit option during the Plan Year.
- Spouse or beneficiary changes coverage during an open enrollment period for his or her employer's plan.
- Loss of coverage under State Children's Health Insurance Program ("SCHIP" under Title XXI of the Social Security Act), under an Indian tribal government, Indian Health Service, or another tribal organization, under a State health benefits risk pool, or under a foreign government group health plan.
- Receipt of a judgment, decree, or order resulting from a divorce, legal separation, annulment, or a change in legal custody (including a Qualified Medical Child Support Order (QMCSO)).

Newborn child
Coverage will be provided for a covered Retiree's newborn child from birth through 30 days after the birth. Coverage will continue beyond that period only if "Retiree plus child(ren)" or "Family" coverage is in effect and the Retiree adds the newborn child as a Dependent or the covered Retiree enrolls in "Retiree plus child(ren)" or "Family" coverage during the special enrollment period. If the newborn is not enrolled during the special enrollment period, he or she can be added as a Dependent during an open enrollment period.

To request special enrollment or to obtain more information of Your Qualified Change in Status, contact Human Resources.

Surviving Spouse / Surviving Dependents
Coverage begins the 1st of the month following Your date of death. You and Your Surviving Spouse/Surviving Dependents must have been covered by the Plan at the time of Your death. The Employer pays the full cost for the Plan for the first period of time as described in When Coverage Terminates. After the Employer-paid coverage period ends, You will be required to make contributions to continue Your coverage under a selected coverage option. The amount of Your contributions depends on the option (Pre-Medicare or Post-Medicare) and the type of coverage category selected.

Medicaid and Children's Health Insurance Program (CHIP) Special Enrollment/Special Enrollees
Eligible Retirees and Dependents may also enroll under two additional circumstances:
- The Retiree's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Retiree or Dependent becomes eligible for a subsidy (state premium assistance program)

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

Special Enrollment Period for Medicare Eligible Retirees/Spouses
Qualified Change in Status for a Retiree/Spouse that is eligible for Medicare must correspond with an involuntary termination of group coverage. Reasons for coverage termination include, but are not limited to:
- Plan termination,
- Death of the primary insured, and/or
- Loss of eligibility.

Important notes
- If a Retiree and/or eligible Spouse, who are eligible for Medicare and enrolled in this Plan, waive participation in this Plan at any time, they will not have another opportunity to enroll in the future. If an involuntary loss of coverage occurs, the Retiree and/or eligible Spouse will only have the opportunity to enroll in the Sentry Retiree Medical Plan – Retiree Reimbursement Arrangement (RRA) Option.
- If the Retiree fails to enroll in a Plan option upon Medicare eligibility, the Retiree permanently waives participation for the Retiree and his or her eligible Spouse in any option offered under the Plan. An otherwise eligible Spouse is not eligible if the Retiree is not enrolled.

- If an eligible Spouse waives participation, the Spouse permanently waives participation for himself or herself only.
- Individuals or Dependents must request coverage within 30 days of a qualifying event.

Changing coverage (adding a Dependent)
You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details. Coverage is provided only for those Dependents the Retiree has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

OBRA 1993 AND QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

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

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

Qualified Medical Child Support Order
For a child who is entitled to coverage under a Qualified Medical Child Support Order (QMCSO), coverage will typically begin on the first day of the month following the Plan’s determination that the QMCSO is qualified:

- The Retiree who is required to provide health coverage is enrolled in the Plan for “Retiree plus child(ren)” or “Family” coverage and pays any required contributions;
- Legal counsel to the Plan renders an opinion as to whether the court order is a QMCSO under Section 609 of the Employee Retirement Income Security Act of 1974 (ERISA); and
- The child who is the subject of the court order would otherwise be eligible for coverage as a Dependent.

The Employer follows certain procedures to determine if an order is a QMCSO. You may receive a copy of these QMCSO procedures at no charge. If You have any questions or would like a copy of the written procedures used to determine whether a QMCSO is valid, please contact Your Human Resources department.

NONDISCRIMINATION

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

COST OF COVERAGE

The cost of Your retiree health care benefits depends on Your points (Your points equal Your age plus Your Years of Service) at Retirement as follows:

- **Retirement Program 1** - If Your age added to Your Years of Service equal at least 85 points (Rule of 85), You will receive retiree health care benefits fully paid by the Company. If You do not meet the Rule of 85, You will be required to contribute 2.5% of the total cost for each point less than 85 (with a maximum retiree payment of 50% of the cost).
- **Retirement Program 2** - If You meet the Rule of 85, You will receive retiree health care benefits for which the Company pays 50% of the cost. If You do not meet the Rule of 85, You will be required to contribute an additional 2.5% of the total cost for each point less than 85 (with a maximum retiree payment of 100% of the cost).
- **Retirement Program 3** – You are not eligible for the Retiree Health Care benefits.

Retirement Program 1
The table below shows the percentage of the total premium you'll pay based on your age and years of service at the time of your retirement.

Years of service	Age at retirement 55	56	57	58	59	60	61	62	63	64	65
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
29	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
28	5.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
27	7.5%	5.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	10.0%	7.5%	5.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	12.5%	10.0%	7.5%	5.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	15.0%	12.5%	10.0%	7.5%	5.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%
23	17.5%	15.0%	12.5%	10.0%	7.5%	5.0%	2.5%	0.0%	0.0%	0.0%	0.0%
22	20.0%	17.5%	15.0%	12.5%	10.0%	7.5%	5.0%	2.5%	0.0%	0.0%	0.0%
21	22.5%	20.0%	17.5%	15.0%	12.5%	10.0%	7.5%	5.0%	2.5%	0.0%	0.0%
20	25.0%	22.5%	20.0%	17.5%	15.0%	12.5%	10.0%	7.5%	5.0%	2.5%	0.0%
19	27.5%	25.0%	22.5%	20.0%	17.5%	15.0%	12.5%	10.0%	7.5%	5.0%	2.5%
18	30.0%	27.5%	25.0%	22.5%	20.0%	17.5%	15.0%	12.5%	10.0%	7.5%	5.0%
17	32.5%	30.0%	27.5%	25.0%	22.5%	20.0%	17.5%	15.0%	12.5%	10.0%	7.5%
16	35.0%	32.5%	30.0%	27.5%	25.0%	22.5%	20.0%	17.5%	15.0%	12.5%	10.0%
15	37.5%	35.0%	32.5%	30.0%	27.5%	25.0%	22.5%	20.0%	17.5%	15.0%	12.5%
14	40.0%	37.5%	35.0%	32.5%	30.0%	27.5%	25.0%	22.5%	20.0%	17.5%	15.0%
13	42.5%	40.0%	37.5%	35.0%	32.5%	30.0%	27.5%	25.0%	22.5%	20.0%	17.5%
12	45.0%	42.5%	40.0%	37.5%	35.0%	32.5%	30.0%	27.5%	25.0%	22.5%	20.0%
11	47.5%	45.0%	42.5%	40.0%	37.5%	35.0%	32.5%	30.0%	27.5%	25.0%	22.5%
10	50.0%	47.5%	45.0%	42.5%	40.0%	37.5%	35.0%	32.5%	30.0%	27.5%	25.0%
9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	27.5%
8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30.0%

Retirement Program 2
The table below shows the percentage of the total premium you'll pay based on your age and years of service at the time of your retirement.

	Age at retirement										
Years of service	**55**	**56**	**57**	**58**	**59**	**60**	**61**	**62**	**63**	**64**	**65**
30	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
29	52.5%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
28	55.0%	52.5%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
27	57.5%	55.0%	52.5%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
26	60.0%	57.5%	55.0%	52.5%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
25	62.5%	60.0%	57.5%	55.0%	52.5%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
24	65.0%	62.5%	60.0%	57.5%	55.0%	52.5%	50.0%	50.0%	50.0%	50.0%	50.0%
23	67.5%	65.0%	62.5%	60.0%	57.5%	55.0%	52.5%	50.0%	50.0%	50.0%	50.0%
22	70.0%	67.5%	65.0%	62.5%	60.0%	57.5%	55.0%	52.5%	50.0%	50.0%	50.0%
21	72.5%	70.0%	67.5%	65.0%	62.5%	60.0%	57.5%	55.0%	52.5%	50.0%	50.0%
20	75.0%	72.5%	70.0%	67.5%	65.0%	62.5%	60.0%	57.5%	55.0%	52.5%	50.0%
19	77.5%	75.0%	72.5%	70.0%	67.5%	65.0%	62.5%	60.0%	57.5%	55.0%	52.5%
18	80.0%	77.5%	75.0%	72.5%	70.0%	67.5%	65.0%	62.5%	60.0%	57.5%	55.0%
17	82.5%	80.0%	77.5%	75.0%	72.5%	70.0%	67.5%	65.0%	62.5%	60.0%	57.5%
16	85.0%	82.5%	80.0%	77.5%	75.0%	72.5%	70.0%	67.5%	65.0%	62.5%	60.0%
15	87.5%	85.0%	82.5%	80.0%	77.5%	75.0%	72.5%	70.0%	67.5%	65.0%	62.5%
14	90.0%	87.5%	85.0%	82.5%	80.0%	77.5%	75.0%	72.5%	70.0%	67.5%	65.0%
13	92.5%	90.0%	87.5%	85.0%	82.5%	80.0%	77.5%	75.0%	72.5%	70.0%	67.5%
12	95.0%	92.5%	90.0%	87.5%	85.0%	82.5%	80.0%	77.5%	75.0%	72.5%	70.0%
11	97.5%	95.0%	92.5%	90.0%	87.5%	85.0%	82.5%	80.0%	77.5%	75.0%	72.5%
10	100.0%	97.5%	95.0%	92.5%	90.0%	87.5%	85.0%	82.5%	80.0%	77.5%	75.0%
9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	77.5%
8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80.0%

Retirement Program 3
You are not eligible for the Retiree healthcare benefits.

When coverage terminates

TERMINATION OF COVERAGE (INDIVIDUAL)

Membership for You and Your enrolled family members may be continued as long as You are a Retiree of the Employer and meet eligibility requirements. Your coverage in the Plan ends at midnight on the earliest of the last day of the month in which:

- You last paid Your share of the Plan's cost;
- You discontinued coverage under the Plan;
- You are no longer eligible for the Plan;
- You are no longer eligible for coverage under COBRA; or
- The Plan terminates.

Your coverage under the Prescription Drug Benefit (see Schedule of Benefits) will end on the last day of the month in which You enroll in a Medicare Part D Prescription Drug Plan, such as a Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug (MA-PD) plan. You will remain ineligible for Prescription Drug Benefits until You disenroll from Medicare Part D and re-enroll in the Plan during an open enrollment period.

Dependent coverage in the Plan will end on the earliest of the last day of the month in which:

- Your coverage ends;
- You last paid Your share of the cost for Dependent coverage under the Plan;
- The Dependent is no longer eligible for coverage under COBRA;
- The Dependent no longer meets the definition of Dependent under the Plan; or
- The Plan terminates.

Coverage of an enrolled child ceases automatically at the end of the month when the child attains the age limit shown in the Eligibility sections or any of the above, whichever occurs first. Coverage of a disabled child over the limiting age ceases if the child is found to be no longer totally or permanently impaired. Coverage of the Spouse of a Subscriber terminates automatically at the end of the month as of the date of divorce or death.

Dependent coverage under the Prescription Drug Benefit (see Schedule of Benefits) will end on the last day of the month in which the Dependent enrolls in a Medicare Part D Prescription Drug Plan, such as a PDP or an MA-PD. The Dependent will remain ineligible for Prescription Drug Benefits until the Dependent disenrolls from Medicare Part D and re-enrolls in the Plan during an open enrollment period.

IMPORTANT INFORMATION ABOUT MEDICARE ELIGIBILITY

Effective January 1, 2015, the Sentry Retiree Medical Plan – Plus Option is limited to Retirees and eligible covered Dependents of Retirees:

1. Who are not eligible for Medicare, or
2. If the Retiree retired prior to January 1, 2000 and have reached Medicare eligibility on or before January 1, 2015 (see the Post-Medicare Eligibility section of this Summary Plan Description), and
3. Who have not participated in the RRA option.

If You are Medicare-eligible at the time of Your retirement or become eligible for Medicare on or after January 1, 2015, the Sentry Retiree Medical Plan – Plus Option is no longer available. This is the case whether or not You actually enroll in Medicare. Refer to the Sentry Retiree Medical Plan – Retiree Reimbursement Arrangement (RRA) option.

Note: if You're under age 65 and only qualify for Medicare Part A, You may be permitted enrollment in the Plan. Once You become eligible for Medicare Part B, You are no longer eligible for the Plan as of the Medicare Part B effective date. Contact Sentry Human Resources for details.

SURVIVING SPOUSE / SURVIVING DEPENDENTS

If You die while covered under the Plan, Your spouse and Dependents who were covered by the Plan at the time of Your death will be given the option of either 1) electing COBRA and continuing coverage under the Plan pursuant to COBRA for up to 36 months, or 2) remaining covered under the plan's surviving spouse and dependent coverage provisions as described directly below.

Under the Plan's surviving spouse and dependent coverage provisions (which is only available if COBRA is not elected), coverage will be provided as follows:

- If the Retiree retired before January 1, 2003 and subsequently dies, then Employer-paid coverage continues for Your spouse and Dependent children until the January 1 following the first anniversary of the Retiree's death. After the Employer-paid coverage period ceases, Your spouse and Dependent children may remain on the plan paying the full premium for the remainder of 36 months. If the required premium is not paid, coverage will be canceled and may not be reinstated. With respect to Dependents, coverage will end on the last day of the month in which the Dependent ceases to be a Dependent under the Plan.
- If the Retiree retired on or after January 1, 2003 and subsequently dies, then Employer-paid coverage continues for Your spouse and Dependent children until the 1st of the month following the date of death plus 18 months. After the Employer-paid coverage period ceases, Your spouse and Dependent children may remain on the plan paying the full premium for the remainder of 36 months. If the required premium is not paid, coverage will be canceled and may not be reinstated. With respect to Dependents, coverage will end on the last day of the month in which the Dependent ceases to be a Dependent under the Plan.

Note that if Your enrolled Spouse and/or Dependent children choose to elect COBRA (thus waiving coverage under the surviving Spouse and Dependent children provision) they may be able to continue coverage under COBRA for up to a maximum of 36 months. Contact Human Resources for information on continuing coverage. See Continuation of Coverage for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

For a child who is entitled to coverage under a Qualified Medical Child Support Order (QMCSO), coverage will end on the last day of the month in which the earliest of the following occurs:

- The QMCSO ceases to be effective;
- The child no longer meets the Plan's definition of a Dependent;
- The date the child has coverage under another plan;
- The Plan terminates;
- The Retiree who is ordered by the QMCSO to provide coverage, is no longer eligible to enroll in this Plan; or
- The Retiree or other party specified under the QMCSO last paid the cost of "Retiree plus child(ren)," or "Family" coverage.

COLLEGE STUDENT MEDICAL LEAVE

The plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a medically necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another plan provision, such as the child's age exceeding the plan's limit.

Medically necessary change in student status

The extended coverage is available if a college student would otherwise lose coverage because a serious illness or Injury requires a medically necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). The plan must receive written certification from the child's physician confirming the serious illness or Injury and the Medical Necessity of the leave or change in status.

Coverage continues even if the plan changes

Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a plan changes during the extended period of coverage.

CONTINUATION OF COVERAGE (FEDERAL LAW-COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with Federal law. If Your Employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA) If Applicable

COBRA continuation coverage is available when Your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your Spouse and Your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of Your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections

at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial qualifying event	Length of availability of coverage
For Employees Voluntary or involuntary termination (other than gross misconduct) or loss of coverage under an Employer's health plan due to reduction in hours worked.	18 months
For Spouses/ Dependents • A covered Employee's voluntary or involuntary termination (other than gross misconduct) or loss of coverage under an Employer's health plan due to reduction in hours worked.	18 months
• Covered Employee's entitlement to Medicare • Divorce or legal separation • Death of a Covered Retiree	36 months
For Dependents • Loss of Dependent child status • Covered Retiree's/Spouse's entitlement to Medicare	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if You become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for Your Spouse and children can last up to 36 months after the date of Medicare entitlement.

If You are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your Employer, and that bankruptcy results in the loss of coverage, You will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event
If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, Your Spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused Your Spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

NOTIFICATION REQUIREMENTS

In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, You or an eligible family member must make an election within 60 days of the date Your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies You or Your family member of this right, whichever is later. You must pay the total premium appropriate for the type of benefit coverage You choose to continue. If the premium rate changes for active associates, Your monthly premium will also change. The premium You must pay cannot be more than 102% of the premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be impaired under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become impaired during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29 month disability extension. (This provision also applies if any covered family member is found to be impaired.) This provision would only apply if the qualified beneficiary provides notice of impairment status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the impaired at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be impaired, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

TRADE ADJUSTMENT ACT ELIGIBLE INDIVIDUAL

If You don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused You to be eligible initially for COBRA coverage under this Plan, You will be entitled to another 60 day period in which to elect COBRA coverage. This second 60 day period will commence on the first day of the month on which You become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

WHEN COBRA COVERAGE ENDS

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The group terminates all of its group welfare benefit plans.

OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

IF YOU HAVE QUESTIONS

Questions concerning Your Group's health Plan and Your COBRA continuation coverage rights should be addressed to the Employer. For more information about Your rights under ERISA, if this Plan is subject to ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

CONTINUATION OF COVERAGE DURING MILITARY LEAVE (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline

for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the premiums and the Employee is only required to pay his or her share of the premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

CONTINUATION OF COVERAGE DUE TO FAMILY AND MEDICAL LEAVE (FMLA)

An Employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An Employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the Employee's child;
- The placement of a child with the Employee for the purpose of adoption or foster care;
- To care for a seriously ill Spouse, child or parent; or,
- A serious health condition rendering the Employee unable to perform his or her job.

If the Employee chooses to continue coverage during the leave, the Employee will be given the same health care benefits that would have been provided if the Employee were working, with the same premium contribution ratio. If the Employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the Employee. It will tell the Employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of premium, the Employee's coverage will be restored to the same level of benefits as those the Employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible Dependents. The Employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

FOR MORE INFORMATION

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.
If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

For more information about Your rights under ERISA, if this Plan is subject to ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at dol.gov/ebsa.

DOUBLE COVERAGE

If you and your spouse are both employees or retirees, no dependents can be double covered by any combination of "Employee plus spouse," "Employee plus child(ren)," "Family," or “Retiree plus family” coverage under the Plan. Additionally, two employees or retirees cannot be enrolled in family coverage under the Plan. No coordination of benefits will occur within the Plan in a situation in which a dependent, employee, or retiree is double covered.

General information

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

FORM OR CONTENT OF SUMMARY PLAN DESCRIPTION
No agent or Employee of the Claims Administrator is authorized to change the form or content of this Summary Plan Description. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

CIRCUMSTANCES BEYOND THE CONTROL OF THE PLAN
In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of Facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical, the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment, but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

PROTECTED HEALTH INFORMATION UNDER HIPAA
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of Your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the Member Services number on Your Identification Card.

USE AND DISCLOSURE OF INFORMATION WITHOUT AUTHORIZATION
The Plan will use and disclose Summary Health Information and Protected Health Information (PHI) to the extent of and in accordance with the uses and disclosures permitted HIPAA. The Plan, and any insurer or health maintenance organization funding benefits provided by the Plan, may disclose Summary Health Information to the Company when requested by the Employer for:

- Obtaining premium bids;
- Modifying, amending or terminating the Plan; and
- Determining whether an Employee is participating or has enrolled or disenrolled in the Plan.

The Plan, and any insurer, will use, and disclose to the Employer, PHI for purposes related to Treatment, Payment and Health Care Operations. "Treatment", "Payment", "Health Care Operations", "Summary Health Information" and "PHI" have the meaning set forth in the privacy regulations implementing HIPAA, as amended from time to time.

USE AND DISCLOSURE OF INFORMATION WITH AUTHORIZATION
The Plan will not disclose PHI to any other Sentry plan or program including the Sentry Short-Term Disability Pay Continuation program, Sentry Flexible Spending Accounts program, Sentry Group Long Term Disability Plan and the Sentry Sales Producers LTD Plan, for purposes related to administration of these plans and programs without an authorization unless otherwise permitted by HIPAA.

DISCLOSURE TO EMPLOYER
With respect to PHI, the Employer agrees to certain conditions. The Employer agrees and, by delivery of a copy of this document, certifies to the Plan that it will:

- Not use or further disclose PHI other than as permitted or required by the Plan Document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan or any insurer, agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an Employee;
- Not use or disclose PHI in connection with any other benefit or Employee benefit plan of the Employer unless authorized by the Employee;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for under this Plan;
- Make PHI available to an Employee in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures in accordance with HIPAA;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan, or an insurer, available to the Health and Human Services Secretary for the purposes of determining the Plan's compliance with HIPAA requirements for PHI; and
- If feasible, return or destroy all PHI received from the Plan or an insurer that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible.

ADEQUATE SEPARATION BETWEEN THE PLAN AND THE EMPLOYER

In accordance with HIPAA, only the following Employees of the Employer may be given access to PHI:

- The Chief Human Resources Officer;
- The Director of Employee Benefits (or, in the event of unavailability, his or her alternate);
- The Benefits Manager (or, in the event of unavailability, his or her alternate); and
- The Health and Wellness Manager (or, in the event of unavailability, his or her alternate).

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Employer performs for the Plan, including payment and health care operations. If the persons described above do not comply with this Plan Document, such as by accessing PHI for other than administrative functions, the Employer shall treat such as a matter to be reviewed under its current disciplinary policies and procedures.

ELECTRONIC PROTECTED HEALTH INFORMATION

With respect to electronic PHI:

- The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan, consistent with the requirements of the HIPAA security regulations and standards.
- The Employer shall ensure that the adequate separation requirement set forth in 45 CFR Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures, consistent with the requirements of the HIPAA security regulations and standards.
- The Employer shall take reasonable steps to ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect such information.
- The Employer shall report to the Plans any Security Incident of which it becomes aware.
- The Plan and this Section of the Plan shall be interpreted and administered in accordance with the HIPAA security regulations and standards, any applicable Federal or State law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section of the Plan and the HIPAA security regulations and standards, statute, regulation, or guidance, such HIPAA security regulations and standards, statute, regulation, or guidance shall govern. "Security Incident" has the meaning set forth in the security regulations and standards implementing HIPAA, as amended from time to time.

WORKER'S COMPENSATION

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent Employer liability or indemnification law.

OTHER GOVERNMENT PROGRAMS

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

MEDICARE

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to Federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and Federal law. Except when Federal law required us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to You shall be reimbursed by or on Your behalf to us, to the extent we have made payment for such services. If You do not enroll in Medicare Part B when You are eligible, You may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when You should enroll, and when You are allowed to delay enrollment without penalties.

A Retiree and his or her eligible Spouse who become eligible for Medicare after January 1, 2015, is no longer eligible for the Plan as of their Medicare effective date.

However, Medicare-eligible Members may continue coverage under the Plan if either one of these situations apply:

1. If the member only qualifies for Medicare Part A, they may be permitted to continue enrollment in the Plan and the Plan will pay Benefits according to the provisions outlined below. Once the Member becomes eligible for Medicare Part B, he or she is no longer eligible for the Plan as of the Medicare Part B effective date.
2. If the Retiree retired prior to January 1, 2000, and the Retiree and his or her eligible Spouse:
    a. Are currently enrolled in the Plan,
    b. Have reached Medicare eligibility on or before January 1, 2015, and
    c. Have not previously participated in the Retiree Reimbursement Arrangement (RRA) option.

If one of the situations above apply to You, the Plan may pay Benefits according to the provisions outlined in the Coordination of Benefits section of this Summary Plan Description.

MEMBER RIGHTS AND RESPONSIBILITIES

The delivery of quality healthcare requires cooperation between patients, their Providers, and their healthcare benefit Plans. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem has adopted a Member Rights and Responsibilities statement.

This statement can be found in the front of this Benefit Booklet in the Member Rights and Responsibilities section or on our website. To access, go to www.anthem.com and select “Member Support.” Under the Support column, select “FAQs” and Your state, then the “Laws and Rights That Protect You” category. Click on the “What are my rights as a member?” question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member’s Identification Card.

RIGHT OF RECOVERY AND ADJUSTMENT

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, the Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

RELATIONSHIP OF PARTIES (EMPLOYER-MEMBER-CLAIMS ADMINISTRATOR)

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

The Employer is fiduciary agent of the Member. The Claims Administrator's notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

RELATIONSHIP OF PARTIES (CLAIMS ADMINISTRATOR – IN-NETWORK PROVIDERS)

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

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

CLAIMS ADMINISTRATOR ANTHEM NOTE

The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Summary Plan Description) constitutes a contract solely between the Employer and Anthem, and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Summary Plan Description.

NOTICE

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business and/or to You at the Subscriber's address as it appears on the records or in care of the Employer.

MODIFICATIONS OR CHANGES IN COVERAGE

The Plan Sponsor may change the benefits described in this Summary Plan Description and the Member will be informed of such changes as required by law. This Summary Plan Description shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

FRAUD

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

ACTS BEYOND REASONABLE CONTROL (FORCE MAJEURE)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and Federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and Federal laws and the Claims Administrator does not assume any responsibility for compliance.

CONFORMITY WITH LAW

Any provision of the Plan which is in conflict with the applicable Federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

CLERICAL ERROR

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

POLICIES, PROCEDURES, AND PILOT PROGRAMS

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply. Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, at its discretion, to institute from time to time, utilization management, care management, case management, clinical quality, disease management, or wellness pilot initiatives in certain designated geographic areas that may result in the payment of benefits not otherwise specified in this Benefit Booklet. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high-quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. The Claims Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to the Employer.

VALUE-ADDED PROGRAMS

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

WAIVER

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

EMPLOYER'S SOLE DISCRETION

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

RESERVATION OF DISCRETIONARY AUTHORITY

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Summary Plan Description. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Summary Plan Description of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Summary Plan Description. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable appeals procedures.

GOVERNMENTAL HEALTH CARE PROGRAMS

Under Federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

MEDICAL POLICY AND TECHNOLOGY ASSESSMENT

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Physicians from various medical specialties including the Claims Administrator's medical directors, Physicians in academic medicine and Physicians in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

HOW TO OBTAIN LANGUAGE ASSISTANCE

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

PAYMENT INNOVATION PROGRAMS

The Claims Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Claims Administrator under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to health care. The Program payments are not made as payment for specific Covered Services provided to You but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by or to the Claims Administrator under the Program(s), and You do not share in any payments made by Network Providers to the Claims Administrator under the Program(s).

CARE COORDINATION

The Plan pays Network Providers in various ways to provide Covered Services to You. For example, sometimes the Plan may pay Network Providers a separate amount for each Covered Service they provide. The Plan may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Plan may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Plan may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Plan because they did not meet certain standards. You do not share in any payments made by Network Providers to the Plan under these programs.

PROGRAM INCENTIVES

The Plan may offer incentives from time to time, at its discretion, in order to introduce You to covered programs and services available under this Plan. The Plan may also offer with discretion the ability for You to participate in certain voluntary health or condition-focused digital applications, or use other technology-based interactive tools, or receive educational information to help You stay engaged and motivated, manage Your health, and assist in Your overall health and well-being. The purpose of these programs and incentives includes, but is not limited to, making You aware of cost-effective benefit options or services, helping You achieve Your best health, and encouraging You to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost-shares. Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. Motivational rewards, awards, or points for achieving certain milestones may be a feature of the program. The Plan may discontinue a program or an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, it is recommended that You consult Your tax advisor.

CONFIDENTIALITY AND RELEASE OF INFORMATION

Applicable state and Federal law requires us to undertake efforts to safeguard Your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of Your medical information is available on our website and can be furnished to You upon request by contacting our Member Services department.

Obligations that arise under state and Federal law and policies and procedures relating to privacy that are referenced but not included in this Summary Plan Description are not part of the contract between the parties and do not give rise to contractual obligations.

Health benefits coverage under Federal law

CHOICE OF PRIMARY CARE PHYSICIAN

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's Network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

ACCESS TO OBSTETRICAL AND GYNECOLOGICAL (OBGYN) CARE

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, www.anthem.com.

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain Providers or Facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

Also, under Federal law, plans may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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

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

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

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the Schedule of Benefits.

If You would like more information on WHCRA benefits, call Your Plan Administrator.

COVERAGE FOR A CHILD DUE TO A QUALIFIED MEDICAL SUPPORT ORDER ("QMCSO")

If You or Your Spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask Your Employer or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the

Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and Out-of-Pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and Out-of-Pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

SPECIAL ENROLLMENT NOTICE

If You are declining enrollment for yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, if You or Your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards You or Your Dependents' other coverage). However, You must request enrollment within 31 days after You or Your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll yourself and Your Dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

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

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

To request special enrollment or obtain more information, call the Member Services telephone number on Your Identification Card or contact Your Plan Administrator.

NOTICE REGARDING RETIREE-ONLY PLANS

If this Plan is issued as part of a retiree-only Plan, as defined by ERISA §732(a) and IRC §9831(a)(2), the provisions of the Consolidated Appropriations Act of 2021 will not apply, including the provisions regarding the No Surprises Act. In a retiree-only Plan, Out-of-Network Providers may bill You for any charges that exceed the Plan's Maximum Allowed Amount. Please contact your Employer or former Employer if You are unsure whether Your Plan is a retiree-only Plan.

Statement of ERISA rights

The Claims Administrators are not responsible for any statements contained herein that are not set forth in the Administrative Services Agreement or the Summary Plan Description.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each Member in an employee benefit Plan. This information is outlined below.

- **Plan Name:** Sentry Retiree Medical Plan – Plus Option

- **Plan Sponsor:**
  Sentry Insurance Company
  1800 North Point Drive
  Stevens Point, WI 54481

- **Plan Number:** 516

- **Employer I.D. Number:** 39-0333950

- **Type of Plan:** The Plan is an Employee welfare benefit plan providing group health benefits.

- **Plan Year Ends:** December 31

- **Type of Administration/Funding:** Health benefits are furnished under a health care plan funded by the Plan Sponsor on a self-funded basis with claims being administered by Anthem Insurance Companies, Inc. and Express Scripts on behalf of Sentry Insurance Company. The benefits paid under this Plan are funded through:
  - Premium payments paid by participants; and
  - Employer contributions paid from the general assets of the Employer.

  These payments and contributions may or may not pass through the Voluntary Employees' Beneficiary Associations (VEBA).

  Anthem Blue Cross and Blue Shield
  P.O. Box 37010
  Louisville, KY 40233

  Express Scripts
  P.O. Box 14711
  Lexington, KY 40512

- **Plan Administrator and Named Fiduciary**
  Sentry Insurance Company
  Attn: Chief Human Resources Officer
  1800 North Point Drive
  Stevens Point, WI 54481
  Phone: 715-346-6550

- **Agent for Service of Legal Process**
  Sentry Insurance Company
  Attn: Chief Human Resources Officer
  1800 North Point Drive
  Stevens Point, WI 54481
  Phone: 715-346-6550

- **Description of Benefits**
  This Summary Plan Description sets forth the benefits provided under this Plan. A brief explanation of these benefits may be found in the section entitled "**Schedule of Benefits**". A more detailed description of the benefits appears in the sections entitled "**Benefits**".

- **Eligibility for Participation**
  The eligibility requirements for participation under this Plan are set forth in the Plan Description in the section entitled "Eligibility".

- **Claims Procedures**
  The Summary Plan Description contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Claims Administrator or the Plan Administrator. Note that the Claims Administrator is neither the Plan Administrator nor the administrator for the purposes of ERISA. See sections entitled "Claims Payment" and "Your Right to Appeal."

GENERAL INFORMATION ABOUT ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a Member of the Plan, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all Plan Documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions;
- Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary financial report.

You have the right to continue health care coverage for Yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents will have to pay for such coverage. Review the "Continuation of Coverage" section in this SPD and the documents governing the plan on rules governing Your COBRA continuation of coverage rights.

You have the right of reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan, if You have creditable coverage from another plan. You should be provided a certificate of creditable coverage free of charge from Your group health plan or health insurance issuer when You lose coverage under the plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of creditable coverage, You may be subject to a preexisting condition exclusion for 12 months (18 months for Late Enrollees) after Your enrollment date in Your coverage.

In addition to creating rights for You and other Employees, ERISA imposes duties on the people responsible for the operation of Your Employee benefit Plan. The people who operate Your Plan are called plan fiduciaries. They must handle Your Plan prudently and in the best interest of You and other Plan Members and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your right under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You must receive a written explanation of the reason for the denial and to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan Administrator and do not receive them within 30 days, You may file suit in a federal court. In such case, the court may require the Plan Administrator to provide You the materials and pay You up to $110 a day until You receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in Federal court. If plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these expenses, for example, if it finds Your claim is frivolous. If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CLAIMS DISCLOSURE NOTICE

This Summary Plan Description contains information on reporting claims, including the time limitations on submitting and appealing a claim. Claim forms may be obtained from the Plan Administrator or the Claims Administrator.

You, Your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Plan and request a review of the adverse benefit determination. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed free of charge; and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

Medical information the Plan or the Claims Administrator has regarding Your case will be released to You or an attorney only by written authorization from Your Provider and/or the Hospital.

Note: ERISA appeals will be administered by the Claims Administrator. Any appeals should be sent to the Claims Administrator.

AMENDMENT OR TERMINATION OF THE PLAN

Future of the Plan

The continuation of the Plan is not guaranteed. The Employer reserves the right to modify, amend, suspend, or terminate the Plan or any provision, benefit, or option under the Plan or level of Employer contribution in relation to all participants or to any class of participants, at any time when in its judgment such action becomes necessary or advisable. The Employer may at any time amend, add, or terminate any self-funding, insurance, on-site Facility, or any other features or options of this Plan in relation to any or all of the classes described above. In addition, the Employer reserves the right to modify or impose required contributions, Copayments, Coinsurance, and Deductibles on Retirees, Dependents, or any class of participants.

Changes in benefits provided under this Plan will be made by the Employer by written direction to the Plan Administrator by the CEO or his/her delegate. This will be followed by written communication to all participants, which the Employer deems reasonably likely to bring such change to the attention of Retirees and their Dependents.

Your benefits in the event of change

In the event that this Plan or any option offered under this Plan is terminated, modified, or suspended, only those benefits that were delivered prior to the date of the change would be covered according to the Plan's or option's provisions. The change to the Plan will not affect Your rights to claim reimbursement for expenses Incurred prior to the change, to the extent such amount is payable under the terms of the Plan prior to the effective date of the change.

Your limitation of rights

Neither the Plan nor any Plan amendment can give a participant or other person any legal or equitable right against the Plan Administrator or the Employer except as stated in this Summary Plan Description. Nothing in the Plan will be construed as a contract of employment or as a limitation of the Employer's right to discharge Employees.

ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Definitions

ACCIDENTAL INJURY
Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

ADMINISTRATIVE SERVICES AGREEMENT
The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan. This Summary Plan Description in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Summary Plan Description or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Summary Plan Description and the Administrative Services Agreement, the Administrative Services Agreement shall control.

AMBULANCE SERVICES
A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

AUTHORIZED SERVICE(S)
A Covered Services rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the Claims Payment section.

BENEFIT PERIOD
One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

CENTERS OF MEDICAL EXCELLENCE (CME) NETWORK
A network of health care Facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

CLAIMS ADMINISTRATOR
The company the Plan Sponsor chose to administer its health benefits. Anthem Blue Cross Blue Shield of Wisconsin e.g. Anthem Insurance Companies, Inc. was chosen to administer the medical benefits of this Plan and Express Scripts was chosen to administer the Prescription Drug benefits of this Plan. The Claims Administrators provide administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

COINSURANCE
Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after You meet Your Deductible. For example, if Your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, Your Coinsurance would be $20 after You meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the Schedule of Benefits for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

COMBINED LIMIT
The maximum total of Network and Out-of-Network benefits available for designated health services in the Schedule of Benefits.

COMPLICATIONS OF PREGNANCY

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

CONGENITAL ANOMALY

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

COORDINATION OF BENEFITS

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

COPAYMENT/COPAY

A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the Schedule of Benefits for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the Provider when services are rendered. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

COSMETIC SURGERY

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

COVERED DEPENDENT

Any Dependent in a Subscriber’s family who meets all the requirements of the Eligibility section of this Summary Plan Description, has enrolled in the Plan, and is subject to administrative service fee requirements set forth by the Plan.

COVERED SERVICES

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member’s Plan, (b) not excluded under such Plan; (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

COVERED TRANSPLANT PROCEDURE

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

CUSTODIAL CARE

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the

maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

DEDUCTIBLE

The portion of the bill You must pay before Your medical expenses become Covered Services. It usually is applied on a calendar year basis.

For Post-Medicare benefits, there is a separate Prescription Drug Deductible. The Prescription Drug Deductible must be satisfied before the Copays apply.

DEPENDENT

A Dependent is:

- A Retiree's legally married spouse (excluding a spouse by common law) at the later of the time of retirement or December 31, 2013. A domestic partner, a divorced spouse, a spouse by common law, or a legally separated spouse is not considered a Dependent and will not be covered under this Plan.
- A Retiree's unmarried child(ren) whom the Retiree or the Retiree's covered spouse is not eligible for Medicare and the Retiree is eligible to claim as a Dependent on his or her taxes for the plan year of coverage. To be claimed for the year of coverage under this Plan the eligible child must satisfy the Internal Revenue Code Section 152 definition of dependent. An eligible child must:
  - Be a natural child, a stepchild, a foster child, a legally adopted child, a child placed with the Retiree for the purposes of legal adoption, a child of the Retiree's spouse, or a child of the Retiree's unmarried Dependent child who is covered under this Plan and has not attained the age of 19 or age 24, if a full-time student;
  - Have the same principal residence as the Retiree, a parent or legal guardian for more than one-half of the taxable year. Exception is granted for temporary absences such as illness, education, business, vacation, or military service;
  - Not have attained the age of 19 or age 24, if a full-time student; and
  - Not have provided more than one-half of his or her own support for the calendar year.
- A Retiree's unmarried child, regardless of age, if mentally or physically disabled, as long as the child was otherwise covered under this Plan as a Dependent and the disability occurred prior to the limiting age

Effective January 1, 2014 an enrolled Dependent child is no longer eligible if the Retiree and the covered spouse, if applicable, are both eligible for Medicare.

DETOXIFICATION

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a Facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

DEVELOPMENTAL DELAY

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age-appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

DIAGNOSTIC SERVICE(S)

Any claim for services performed to diagnose an illness or Injury, which may include, but is not limited to, ultrasounds, X-rays, and MRIs. Please refer to the **Schedule of Benefits** for more details about Your benefit coverage.

DISABILITY
Total Disability for purposes of qualifying for and receiving a benefit from the Employer's Long-Term Disability Plans (LTD).

DURABLE MEDICAL EQUIPMENT
Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

EFFECTIVE DATE
The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

ELECTIVE SURGICAL PROCEDURE
A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

EMERGENCY MEDICAL CONDITION
("Emergency Services," "Emergency Care," or "Medical Emergency")
Emergency Medical Condition means a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:
- Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

EMPLOYEE
A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer regularly scheduled at least 20 hours per work week. The Employee is also called the Subscriber.

EMPLOYER
An Employer, Sentry Insurance Company and any subsidiary or affiliated company whose board of directors elects its company to become a participating company in this Plan subject to approval by the Chief Executive Officer (CEO) of Sentry Insurance Company, who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

EXPERIMENTAL/INVESTIGATIVE
Any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator determined that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:
- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

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

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive.

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other Federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or Facilities or by other treating Physicians, other medical professionals or Facilities studying substantially the same Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

FACILITY

A Facility, including but not limited to, a Hospital, Freestanding Ambulatory Surgery Center, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this Summary Plan Description. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

FORMULARY

A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to, (1) a listing of preferred Prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator, and are dispensed to Members through pharmacies that are Network Providers, and (2) Precertification rules. This list is subject to periodic review and modification. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Formulary.

FREESTANDING AMBULATORY SURGERY CENTER

A Facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis (no patients stay overnight). The Facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed and accredited by the appropriate agency and approved by the Claims Administrator. A Physician’s office does not qualify as a Freestanding Ambulatory Surgery Center.

GROUP HEALTH PLAN, OR PLAN

An employee welfare benefit plan (as defined in Section 3(1) of ERISA) established by the Employer, in effect as of the Effective Date.

HOME HEALTH CARE
Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

HOME HEALTH CARE AGENCY
A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

HOSPICE
A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

HOSPICE CARE PROGRAM
A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

HOSPITAL
A Facility licensed as a Hospital as required by law that satisfies the Claims Administrator's accreditation requirements and is approved by the Claims Administrator. The term Hospital does not include a Provider, or that part of a Provider, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care, educational care, and subacute care.

HOSPITALIST
A dedicated in-patient Physician who works exclusively in a Hospital, providing healthcare services within the scope of an applicable license, satisfies the Claims Administrator's accreditation requirements, and for Network Providers is approved by the Claims Administrator.

IDENTIFICATION CARD
The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

INELIGIBLE CHARGES
Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

INELIGIBLE PROVIDER
A Provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a Provider are not eligible for payment.

IN-FOR-OUT BENEFIT TREATMENT
A Covered Service rendered by an Out-of-Network Provider, authorized in advance by the Claims Administrator to be paid at the Network level. This is also referred to as Out-of-Network Referrals.

INCURRED
The date the service is rendered or the supply is obtained, including phases or steps of treatment.

INFERTILE OR INFERTILITY
The condition of a presumably healthy Member who is unable to conceive or produce conception. This does not include conditions such as when the cause is a vasectomy, orchiectomy, tubal-ligation or hysterectomy.

INITIAL ENROLLEE
A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

INJURY
Bodily harm from a non-occupational accident.

IN-NETWORK PROVIDER
A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or Facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements. A Network Provider for one Plan may not be a Network Provider for another. Please see “How to Find a Provider in the Network” in the section How Your Plan Works for more information on how to find a Network Provider for this Plan. For Wisconsin residents, only POS Providers are Network Providers.

INPATIENT
A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

INTENSIVE CARE UNIT
A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

INTENSIVE OUTPATIENT PROGRAMS
Structured, multidisciplinary mental health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

INTENSIVIST
A board-certified Physician who provides special care for critically ill patients within the scope of an applicable license, satisfies the Claims Administrator’s accreditation requirements, and for Network Providers is approved by the Claims Administrator

LATE ENROLLEES
Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member’s Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

MATERNITY CARE
Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother’s Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

MAXIMUM ALLOWED AMOUNT
The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the Claims Payment section.

MEDICAL NECESSITY (MEDICALLY NECESSARY)
Procedures, supplies, equipment, or services that we conclude are:
1. Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
2. Given for the diagnosis or direct care and treatment of the medical condition; and
3. Within the standards of good medical practice within the organized medical community; and
4. Not mainly for the convenience of the Doctor or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, or service must meet the following requirements:
1. There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and

2. Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and
3. For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of Your illness, Injury or disease, the service is: (1) not more costly than another service or group of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

MEMBER
Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

MENTAL HEALTHCARE
Includes services for mental health and substance use disorder. Mental health and substance use disorder are conditions listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance use disorder condition.

MEDICARE
Title XVIII of the Social Security Act, as amended, including Part A and Part B.

MEDICARE PART D
The Medicare Prescription Drug program under Part D of Title XVIII of the Social Security Act, as amended.

NEW HIRE
A person who is not employed by the Employer on the original Effective Date of the Plan.

NON-COVERED SERVICES
Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

OUT-OF-NETWORK PROVIDER
A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Surgery Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers. For Wisconsin residents, only POS Providers are Network Providers.

OUT-OF-NETWORK REFERRALS
A Covered Service rendered by an Out-of-Network Provider, authorized in advance by the Claims Administrator to be paid at the Network level. This is also referred to as In-For-Out Benefit Treatment.

OUT-OF-POCKET MAXIMUM
The plan's Out-of-Pocket Maximum is the most that You will pay toward covered health expenses in a Plan year once You reach the Out-of-Pocket Maximum under the Plan, the Plan pays 100% of Covered Services for In-Network Providers and 100% of the Maximum Allowable Amount for Out-of-Network Providers.

Your Out-of-Pocket Maximum is described in the Schedule of Benefits.

Note: The Out-of-Pocket Maximum includes all Deductibles, Coinsurance, and emergency room Copayment You incur in a Benefit Period. Once the Out-of- Pocket Limit is satisfied, no additional Coinsurance/Copayments will be required for the remainder of the Benefit Period.

In-Network and Out-of-Network Coinsurance are not separate and do accumulate toward each other.
For Pre-Medicare benefits, there is a separate Prescription Drug Out-of-Pocket Maximum. Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance/Copayments will be required for the remainder of the Benefit Period.

PARTIAL HOSPITALIZATION PROGRAM
Structured, multidisciplinary mental health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

PHARMACY
An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

PHYSICAL THERAPY
The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

PHYSICIAN
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery, Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

PLAN
The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits. The Plan as originally established on January 1, 2011 and amended from time to time.

PLAN DOCUMENT
This Summary Plan Description in conjunction with the Plan Document, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Summary Plan Description or the Plan Document and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Summary Plan Description and the Plan Document, the Plan Document shall control.

PLAN ADMINISTRATOR
The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. The Plan Administrator is not the Claims Administrator.

PLAN SPONSOR
The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. The Plan Sponsor is not the Claims Administrator.

PRESCRIPTION DRUGS
A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or Injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin.

PRIMARY CARE PHYSICIAN
A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

PRIOR AUTHORIZATION/PRECERTIFICATION/PREAUTHORIZATION

The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

PROVIDER

A professional or Facility licensed when required by law that provides healthcare services within the scope of an applicable license, satisfies the Claims Administrator's accreditation requirements, and for Network Providers, is approved by the Claims Administrator on behalf of the Employer. Details on the Plan's accreditation requirements can be found at https://www.anthem.com/provider/credentialing/. This includes any Provider that state law says must be covered under this Plan when they give You Covered Services. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question about a Provider not described in this Benefit Booklet, please call the number on the back of Your Identification Card.

QMCSO, OR MCSO – QUALIFIED MEDICAL CHILD SUPPORT ORDER OR MEDICAL CHILD SUPPORT ORDER

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the Plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- Provides for child support payment related to health benefits with respect to the child of a Group Health Plan Member or requires health benefit coverage of such child in such Plan, and is ordered under state domestic relations law; or
- Enforces a state law relating to medical child support payment with respect to a Group Health Plan.

RESIDENTIAL TREATMENT CENTER/FACILITY

An Inpatient Facility that treats mental health and substance abuse conditions. The Facility must be licensed as a Residential Treatment Center in the state in which it is located and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial care
- Educational care

RETAIL HEALTH CLINIC

A Facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

RETIREE

An Employee who is hired prior to January 1, 2010 and who meets the eligibility requirements to be a Retiree on the date he or she withdrawals from his or her Sentry Insurance active employment, occupation, business, or office or Disability may participate in the Plan during his or her retirement years.

RETIREMENT

The date an Employee who is hired prior to January 1, 2010 withdrawals from his or her Sentry Insurance active employment, occupation, business, or office or Disability.

RETIREMENT PROGRAM 1

Employees who were hired by the Company prior to January 1, 2006 and were at least age 40 as of December 31, 2005 and chose Retirement Program 1.

RETIREMENT PROGRAM 2
Employees who were hired or rehired by the Company after December 31, 2005 and prior to January 1, 2010, Employees who were actively employed and who were under age 40 as of December 31, 2005, or Employees who were actively employed and at least age 40 as of December 31, 2005 and chose Retirement Program 2.

RETIREMENT PROGRAM 3
Employees who were hired or rehired by the Company after December 31, 2009.

SEMIPRIVATE ROOM
A Hospital room which contains two or more beds.

SKILLED CONVALESCENT CARE
Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

SKILLED NURSING FACILITY
A Facility licensed as a Skilled Nursing Facility in the state in which it is located that satisfies the Claims Administrator's accreditation requirements and, for Network Facilities, is approved by the Claims Administrator.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care, or domiciliary care, or a place for rest, educational, or similar services.

SPECIALIST (SPECIALTY CARE PHYSICIAN\PROVIDER OR SCP)
A Specialist is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

SPECIALTY DRUGS
Typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

SPOUSE
For the purpose of this Plan, a Spouse is defined as a Retiree's legally married spouse at the later of the time of retirement or December 31, 2013. A domestic partner, divorced spouse, spouse by common law, or legally separated spouse is not considered a Dependent and will not be covered under this Plan unless otherwise required by state law not pre-empted by ERISA.

TELEHEALTH
Consultations with your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet).

TELEPHONIC
Consultations with your physician (PCP/Specialist) using audio only (telephone).

THERAPEUTIC EQUIVALENT
Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

TRANSPLANT PROVIDERS
A Provider that has been designated as a "Center of Medical Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.
- Out-of-Network Transplant Provider – Any Provider that has NOT been designated as a "Center of Medical Excellence" for Transplants by the Claims Administrator or has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

URGENT CARE

Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

UTILIZATION REVIEW

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or mental health services, procedures, and/or Facilities.

VIRTUAL VISITS

Virtual Visits are also known as Online Visits, Telehealth, and Telemedicine. These visits are a method of consulting with Your Physician (PCP/Specialist) using visual and/or audio devices (Computer, Smart Phone, Tablet).

YEAR(S) OF SERVICE

At least 1,000 hours of service completed within an anniversary year.

YOU AND YOUR

Refer to the Subscriber, Member and each Covered Dependent.

Medical benefits

If You are a participant in the Sentry Retiree Medical Plan – Plus Option, You are automatically enrolled in medical coverage. The coverage is provided through Anthem Blue Cross Blue Shield (the medical Claims Administrator).

This Summary Plan Description (SPD) provides details about the medical benefits available to You through Anthem Blue Cross Blue Shield, including covered services, services that are not covered, and limitations and exclusions that apply.

Schedule of benefits

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

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from a Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When You use an Out-of-Network Provider You may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the Claims Payment section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

TRADITIONAL HEALTH COVERAGE

The Plan offers Traditional Health Coverage to protect You and Your family in case You have significant health care expenses. This coverage is called Traditional Health Coverage, and is made available by Your Employer on a self-insured basis.

Any day and dollar limits associated with specific benefits under this Plan option apply while You are using the Traditional Health Coverage portion of the Plan.

PRE-MEDICARE RETIREES

Calendar year Deductible

Before the Plan begins to pay benefits, You must meet any Deductible required. All Covered Services are subject to the Deductible unless otherwise specified in this Summary Plan Description. Charges in excess of the Maximum Allowed Amount do not contribute to the Deductible. There are not separate Deductibles for In-Network and Out-of-Network expenses.

Coverage level	Calendar year Deductible
Retiree only	$1,300
Retiree plus family	$1,300 per person; maximum $2,600

Your Plan has an embedded Deductible which means:

- If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You.

- If You also cover Dependents (other family members) under this Plan, both the “Individual” and the “Family” amounts apply. The “Family” Deductible amounts can be satisfied by any combination of family members but You could satisfy Your own “Individual” Deductible amount before the “Family” amount is Met (Unless Otherwise Specified) met. You will never have to satisfy more than Your own “Individual” Deductible amount. If You meet Your “Individual” Deductible amount, Your other family member’s claims will still accumulate towards their own “Individual” Deductible and the overall “Family” amounts. This continues until Your other family members meet their own “Individual” Deductible or the entire “Family” Deductible is met.

OUT-OF-POCKET MAXIMUM

The Plan’s Out-of-Pocket Maximum is the most that You will pay toward covered health expenses in a Plan year. Once You reach the Out-of-Pocket Maximum under this Plan option, the Plan pays 100% of Covered Services for In-Network Providers and 100% of the Maximum Allowable Amount for Out-of-Network Providers.

The Out-of-Pocket Maximum includes Your Deductible and Coinsurance You incur in a Benefit Period. The Out-of-Pocket Maximum does not include Pre-Certification penalties, charges in excess of the Maximum Allowed Amount, Non-Covered Services, or any prescription Copay assistance which is not paid for by the Member.

The Plan also has a separate Prescription Drug Out-of-Pocket Maximum for Pre-Medicare Members. It includes Prescription Drug Copayments. Once the Prescription Drug Out-of-Pocket maximum is met, the Plan covers 100% of the cost of covered prescriptions for the remainder of the Calendar Year.

In-Network and Out-of-Network Coinsurance and Out-of-Pocket Maximums are not separate and do accumulate toward each other.

Coverage level	Medical Out-of-Pocket Maximum	Prescription Drug Out-of-Pocket Maximum
Retiree only	$3,900	$2,500
Retiree plus family	$3,900 per person; maximum $7,800	$2,500 per person, maximum $5,000

Your Plan has an embedded Out-of-Pocket which means:

- If You, the Subscriber, are the only person covered by this Plan, only the “Individual” amounts apply to You.
- If You also cover Dependents (other family members) under this Plan, both the “Individual” and “Family” amounts apply. The “Family” Out-of-Pocket amounts can be satisfied by any combination of family members but You could satisfy Your own “Individual” Out-of-Pocket amount before the “Family” amount is met. You will never have to satisfy more than Your own “Individual” Out-of-Pocket amount. If You meet Your “Individual” amount, other family member’s claims will still accumulate towards their own “Individual” Out-of-Pocket and the overall “Family” amounts. This continues until Your other family members meet their own “Individual” Out-of-Pocket or the entire “Family” Out-of-Pocket is met.

POST-MEDICARE RETIREES

Calendar year Deductible

Before the Plan begins to pay benefits, You must meet any Deductible required. All Covered Services are subject to the Deductible unless otherwise specified in this Summary Plan Description. Charges in excess of the Maximum Allowed Amount do not contribute to the Deductible. There are not separate Deductibles for In-Network and Out-of-Network expenses.

You must meet the separate Prescription Drug Deductible before the Prescription Drug Copayments apply. For Prescription Copayment information, refer to the Prescription Benefits section of this SPD.

Coverage level	Medical Deductible	Prescription Drug Deductible
Retiree only	$1,000	$100

Retiree plus spouse	$1,000 per person; maximum $2,000	$100 per person; maximum $200

Your Plan has an embedded Deductible which means:

- If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You.
- If You also cover Dependents (other family members) under this Plan, both the "Individual" and the "Family" amounts apply. The "Family" Deductible amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Deductible amount before the "Family" amount is Met (Unless Otherwise Specified) met. You will never have to satisfy more than Your own "Individual" Deductible amount. If You meet Your "Individual" Deductible amount, Your other family member's claims will still accumulate towards their own "Individual" Deductible and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Deductible or the entire "Family" Deductible is met.

Out-of-Pocket Maximum

The Plan's Out-of-Pocket Maximum is the most that You will pay toward covered health expenses in a Plan year. Once You reach the Out-of-Pocket Maximum under this Plan option, the Plan pays 100% of Covered Services for In-Network Providers and 100% of the Maximum Allowable Amount for Out-of-Network Providers.

The Out-of-Pocket Maximum includes Your Medical Deductible and Coinsurance You incur in a Benefit Period. The Out-of-Pocket Maximum does not include Prescription Drug charges, Pre-Certification penalties, charges in excess of the Maximum Allowed Amount, Non-Covered Services, or any prescription Copay assistance which is not paid for by the Member.

In-Network and Out-of-Network Coinsurance and Out-of-Pocket Maximums are not separate and do accumulate toward each other.

Coverage level	Out-of-Pocket Maximum
Retiree only	$2,600
Retiree plus spouse	$2,600 per person, maximum $5,200

Your Plan has an embedded Out-of-Pocket which means:

- If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You.
- If You also cover Dependents (other family members) under this Plan, both the "Individual" and "Family" amounts apply. The "Family" Out-of-Pocket amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Out-of-Pocket amount before the "Family" amount is met. You will never have to satisfy more than Your own "Individual" Out-of-Pocket amount. If You meet Your "Individual" amount, other family member's claims will still accumulate towards their own "Individual" Out-of-Pocket and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Out-of-Pocket or the entire "Family" Out-of-Pocket is met.

COINSURANCE

When using the Traditional Health Coverage, You pay a certain percentage of the cost of Covered Services through Coinsurance. If You are a Retiree enrolled in the Plan, Your coverage depends on Your eligibility and Medicare status:

1. **Pre-Medicare**: For eligible Pre-Medicare Retirees/Spouses, the Plan generally pays 80% of the In-Network Maximum Allowed Amount (60% of the Out-of-Network Maximum Allowed Amount) and You are responsible for 20% of the In-Network Maximum Allowed Amount (40% of the Out-of-Network Maximum Allowed Amount) after the Deductible has been satisfied. Once You reach the annual Out-of-Pocket Maximum, the Plan pays 100% of the Maximum Allowed Amount in excess of the Out-of-Pocket Maximum.
2. **Post-Medicare**: For eligible Post-Medicare Retirees/Spouses, the Plan generally pays 80% of the Maximum Allowed Amount and You are responsible for 20% of the Maximum Allowed Amount after the Deductible has been satisfied and taking into account the Medicare carve-out. Once You reach the annual Out-of-Pocket Maximum, the Plan pays 100% of the Maximum Allowed Amount in excess of the Out-of-Pocket Maximum.

Note: Charges that are allowed by Medicare are not considered by this Plan (no payments will be made by the Plan) until the Out-of-Pocket Maximum has been met. Charges that are denied by Medicare will be subject to the Deductible, Coinsurance, and Out-of-Pocket Maximum. Refer to the Post-Medicare Eligibility section for information on Your eligibility for this Plan.

All payments are based on the Maximum Allowed Amount and any negotiated arrangements. If You use Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. Depending on the service, this difference can be substantial.

Coinsurance after the calendar year Deductible is met (unless otherwise specified)	In-Network	Out-of-Network
Plan Pays	80%	60%
Member Pays	20%	40%

COPAYMENT

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

Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the section below Unless otherwise indicated, services which are not specifically identified in this Summary Plan Description as being subject to a Copayment are subject to the calendar year Deductible and payable at the percentage payable in this Schedule of Benefits.

COVERAGE FOR THE RETIREE AND ELIGIBLE DEPENDENTS

This Summary Plan Description describes the benefits a Retiree and his or her Covered Dependents may receive under this health care Plan. The Retiree and Covered Spouse is also called a Subscriber.

FINANCIAL TOOLS

Each Plan offers online financial tools to help You keep track of Your health care dollars. Plus, You can track Your claims for Covered Services. You can review what You have spent on health care, view Your balance, or look up the status of a particular claim any time of the day.

SCHEDULE OF BENEFITS

Unless otherwise noted, all services are subject to the Deductible and then Coinsurance.

All payments are based on the Maximum Allowed Amount and any negotiated arrangements. If You use Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. Depending on the service, this difference can be substantial.

Service	In-Network Pre- and post-Medicare	Out-of-Network Pre-Medicare only
Allergy Care • Testing – Physician or Specialist Physician • Treatment – Physician or Specialist Physician • Serum and Allergy Shots/Injections (Network not subject to the calendar year Deductible) – Physician or Specialist Physician • Serum and allergy shots/Injections (Network not subject to the calendar year Deductible) – Outpatient Hospital Facility • Serum and allergy shots/Injections (Network not subject to the calendar year Deductible) – Urgent Care	20%	40%

Mental Health / Substance Abuse Care • Hospital Inpatient Services • Outpatient services • Physician Services (in-person and/or virtual) and Intensive In-Home Mental Health Programs • LiveHealth Online – Virtual visits from Out-of-Network Online Providers (whether accessed directly or through our mobile app.), and Out of Network Intensive In-Home Mental Health Programs are not covered.	20%	40%
Cellular and Gene Therapy Services Precertification required	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Clinical Trials – please see Clinical Trials under Benefits section for more information.	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Colonoscopy	20%	40%
Dental & Oral Surgery / TMJ Services • Accidental Injury to natural teeth - • Oral Surgery / TMJ - Subject to Medical Necessity – excludes appliances and orthodontic treatment	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Diagnostic Physician's Services (including second opinion) by a Physician or specialist Physician during an office visit or home visit. • Primary Care Physician • Specialist Physician • Diagnostic X-ray and Lab – office or independent lab	20%	40%
Note Diagnostic services are defined as any claim for services performed to diagnose an Illness or Injury.		

<table>
<tr><th>Service</th><th>In-Network
Pre- and post-Medicare</th><th>Out-of-Network
Pre-Medicare only</th></tr>
<tr><td>Emergency room for an Emergency Medical Condition (for a Medical Emergency)</td><td>$150 Copay* then 20%</td><td>$150 Copay* then 20%**</td></tr>
<tr><td>Emergency Room Physician for an Emergency Medical Condition</td><td>20%</td><td>20%**</td></tr>
<tr><td>Use of an Emergency Room for non-Emergency Medical Conditions</td><td>$150 Copay* then 20%</td><td>$150 Copay* then 40%</td></tr>
<tr><td>Emergency Room Physician for non-Emergency Medical Conditions</td><td>20%</td><td>40%</td></tr>
<tr><td>Urgent Care clinic visit</td><td>20%</td><td>40%</td></tr>
<tr><td>Ground Ambulance Services for medical emergencies and accidental injuries
• Use of Out-of-Network ambulance services for non-emergencies is subject to the Out-of-Network Coinsurance (you pay 40%).
• If an Out-of-Network Provider is used, however, You may be responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.</td><td>First $500 per year covered in full, then 20%</td><td>First $500 per year covered in full, then 20%</td></tr>
<tr><td>Air Ambulance Services when medically necessary
• Use of Out-of-Network ambulance services for non-emergencies is subject to the Out-of-Network Coinsurance (you pay 40%).
• Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Refer to the Health Care Management-Precertification section for more information.</td><td>First $2,000 per year covered in full, then 20%</td><td>First $2,000 per year covered in full, then 20%</td></tr>
<tr><td colspan="3">*The ER copay is waived if admitted.
**Care received Out-of-Network for an Emergency Medical Condition will be provided at the In-Network level of benefits and the claim will be processed at billed charges if the following conditions apply: 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 one of the following conditions: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part.

Note: Emergency room is for a Medical Emergency. If an emergency visit is rendered in an office setting, the $150 Emergency Room Copayment will apply.</td></tr>
<tr><td>Eye Care office visit – medical eye care exams for treatment of disease or Injury to the eye.

Note
• Routine eye exams are not a Covered Service for ages 19 and up.
• Vision Screenings as part of a wellness exam are covered subject to Deductible and Coinsurance.</td><td>20%</td><td>40%</td></tr>
</table>

Service	In-Network Pre- and post-Medicare	Out-of-Network Pre-Medicare only
Hearing Care • Office visit – Audiometric exam / hearing evaluation test • Cochlear Implants (when Medically Necessary)	20%	40%
Home Health Care Services • Maximum Home Care visits (does not apply to Private Duty Nursing benefit): 100 per calendar year combined In-Network and Out-of-Network. • Maximum Private Duty Nursing visits (Precertification required): 42 days per calendar year combined In-Network and Out-of-Network.	20%	40%
Hospice Care Services	20%	40%
Hospital Inpatient Services – Precertification required. • Room and board (Semiprivate or ICU/CCU) • Hospital services and supplies: x-ray, lab, anesthesia, surgery (Pre-Certification required), Inpatient Physical Therapy, etc. • Pre-Admission testing • Physician services*: Anesthesiologist, Radiologist, Assistant Surgeon, Emergency Services, Neonatologist, Diagnostic Services, Hospitalist, Intensivist, Pathologist	20%	40%
* Anesthesiologists, radiologists, assistant surgeons, Emergency services, neonatologists, diagnostic services, Hospitalists, Intensivists, and pathologists' charges are always paid at the In-Network level of benefits (Coinsurance) when providing Inpatient services.		
Maternity Care & other Reproductive Services	20%	40%
Global care (includes pre-natal and post-natal, delivery): • Primary Care Physician (includes obstetrician and gynecologist) • Specialist Physician • Midwife (Precertification required)	20%	40%

Service	**In-Network** Pre- and post-Medicare	**Out-of-Network** Pre-Medicare only
Physician Hospital/Birthing Center Services (Precertification required): • Physician's services • Newborn nursery services (well baby care) • Circumcision **Note** Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified.	20%	40%
Infertility Services – Limited Coverage Diagnostic Services and Limited Treatment • Covered up to diagnosis and for treatment of an underlying medical Condition. • Non-Covered Services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.	20%	40%
Sterilization Services (Precertification required for Inpatient procedures) • Tubal Ligation • Vasectomy	20%	40%
Medical Supplies and Equipment • Medical Supplies • Durable Medical Equipment • Orthotics (Foot and Shoe) • Prosthetic Appliances (external) **Note:** Wigs/ toupees, if needed as a result of cancer treatment, are covered up to maximum of one per calendar year, subject to Deductible and then Coinsurance, combined In- and Out-of-Network.	20%	40%
Nutritional Counseling for Diabetes	20%	40%
Nutritional Counseling for Mental Health / Substance Abuse	20%	40%
Outpatient Hospital/Facility services • Outpatient Facility • Lab, x-ray, CT scans, and MRI services (Precertification may be required) • Outpatient Physician services (radiologist, anesthesiologist, pathologist, surgeon, etc.)	20%	40%
Office Surgery	20%	40%
Virtual Visits (Telemedicine) **Note:** A Virtual Visit is defined as Telehealth, Online, and Telemedicine.	20% for LiveHealth Online	40% for Out-of-Network and non-LiveHealth Online Providers

Service	**In-Network** Pre- and post-Medicare	**Out-of-Network** Pre-Medicare only
Physician Services (in person and/or virtual) • Primary Care Physician • Specialist Physician Telehealth – Consultation with your Physician (PCP/Specialist) using visual and audio (computer, SmartPhone, Tablet) LiveHealth Online - Virtual visits from Out-of-Network Online Providers (whether accessed directly or through our mobile app.)	20%	40%
Prescription Injectables / Prescription Drugs administered in the Physician's Office	20%	40%
Prescription Injectables / Prescription Drugs Dispensed at a Pharmacy or through home delivery	Refer to the Prescription Benefits section of this SPD	Refer to the Prescription Benefits section of this SPD
Preventive Services (regardless of Provider or setting where Preventive care is provided)	20%	40%
Skilled Nursing Facility • 60-day limit per calendar year (combined In- and Out-of-Network)	20%	40%
Surgical Services	20%	40%
Bariatric Surgery	20%	Not Covered

BLUE DISTINCTION BARIATRIC SERVICES BENEFIT

This benefit description applies to the Bariatric surgery, the pre-determination of eligibility by the Blue Distinction (BD) Bariatric Specialty Care Management unit, travel to a BD Designated Center of Medical Excellence (CME) provider associated with the surgery event, and the after care provided by the BD Bariatric Specialty Care Management unit only.

Designated BD Bariatric CME
For the Covered Bariatric Procedure, You will pay 20% of the Maximum Allowable Amount. Prior to and after the Covered Bariatric Procedure, Covered Services will be paid as Inpatient Services, outpatient services or Physician Home Visits and Office Services depending where the service is performed.

Out-of-Network Bariatric provider
There is NO benefit.

Transportation and Lodging
Maximum $1,000, when services are rendered at a Designated BD Bariatric CME (only). Distance the patient must live from the transplant Facility to use this benefit: 75 Miles. MEALS NOT COVERED.

Note: Participation in Anthem BD Bariatric Specialty Care Management Program is required for benefits to be considered.

Therapy Services (outpatient)	20%	40%

- Physical Therapy– limited to 25 visits per calendar year, combined In-Network and Out-of-Network
- Occupational Therapy
- Speech Therapy

Note: Visit limits do not apply to Mental Health/Substance Abuse diagnoses.

Service	**In-Network** Pre- and post-Medicare	**Out-of-Network** Pre-Medicare only

- Cardiac Rehabilitation
- Chiropractic Care – limited to 12 visits per calendar year (not combined with any other therapy), combined In-Network and Out-of-Network
- Radiation Therapy
- Chemotherapy
- Respiratory Therapy

Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.

TRANSPLANTS

Care must be provided by a Blue Distinction Center for Transplants (BDCT) for coverage. When performed by a non-Blue Distinction Center provider, there is no coverage. You are responsible for any charges from the non-BDCT provider. Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, including Medically Necessary preparatory myeloablative therapy. The Center of Medical Excellence requirements do not apply to cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.

Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are In-Network Transplant Providers that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as a Network Transplant Provider by the Blue Cross and Blue Shield Association. (When calling Member Service, ask to be connected with the Transplant Case Manager for further information.)

Centers of Medical Excellence (CME) Transplant Providers

Blue Distinction Center Facility: Blue Distinction Facilities have met or exceeded national quality standards for care delivery.

Centers of Medical Excellence (CME): Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery.

Network Transplant Provider: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant.

Out of Network (PAR) Transplant Provider: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.

TRANSPLANT BENEFIT PERIOD

Covered Procedure Benefit Period for Network Providers

The number of days or the applicable case rate / global time period will vary, depending on the type of covered procedure and the approved Network Provider agreement.

Before and after the covered procedure Benefit Period, Covered Services will be covered as Inpatient services, outpatient services, home visits, or office visits, depending on where the service is performed.

Centers of Medical Excellence/ Network Transplant Provider

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Centers of Medical Excellence Network Transplant Provider agreement. Contact the Member Services number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)

Service	In-Network Pre- and post-Medicare	Out-of-Network Pre-Medicare only
Covered Transplant Procedure during the Transplant Benefit Period • Care coordinated through an In-Network Transplant Provider/ Center of Medical Excellence, not subject to Deductible	20%	Not Covered
Note Care coordinated through a Network Transplant Provider/ Center of Medical Excellence – not subject to Deductible. When performed by Out-of-Network Transplant Provider (subject to Deductible, does not apply to the Out-of-Pocket Maximum). You are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.		
Bone Marrow & Stem Cell Transplant (Inpatient & outpatient) (Precertification Required) • Includes unrelated donor search up to $30,000 per transplant.	20%	Not Covered
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)	20%	Not Covered
Eligible Travel and Lodging • Limited to $50 per day for double occupancy for lodging, benefit limit for transplants $10,000 per transplant.	Covered at 100% when BDCT Facility is used	Not Covered

ANTHEM BLUE CROSS AND BLUE SHIELD IS THE TRADE NAME OF:

In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Company (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

IT'S IMPORTANT WE TREAT YOU FAIRLY

That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on Your Identification Card for help (TTY/TDD: 711). If You think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, You can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Total health and wellness solution

QUICK CARE OPTIONS

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

ANTHEM HEALTH GUIDE

Anthem Health Guide provides You with enhanced member services support. You can contact a health guide with questions about benefits, programs for Your health, help scheduling doctor's appointments, comparing costs for procedures, and more. Health guides can connect You with knowledgeable health professionals to help You manage chronic conditions, deal with an illness, or provide support for emotional concerns like anxiety or depression. Reach out to Member Services and our health guides via phone, email, app, or even chat online.

BUILDING HEALTHY FAMILIES

This digital program can help support Your family from preconception through the stages of pregnancy, childbirth, and early childhood (to age 5 and beyond). It is available 24/7 through our Sydney Health mobile app, and at www.anthem.com, and features an extensive content library covering topics to support diverse families, including single parents and same-sex or multicultural couples. In addition, the app features many tools including fertility, diaper change, and feeding trackers, due date calculators, and blood pressure monitoring. Visit the Sydney Health app or www.anthem.com to enroll today.

COMPLEXCARE

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

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

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

CONDITIONCARE PROGRAMS

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

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

You will receive:

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

ConditionCare Support Programs

ConditionCare Support programs are designed to help You better manage the following conditions:

- Low Back Pain – focuses on disorders of the lumbar region.
- Musculoskeletal – addresses arthritis, osteoporosis and hip/knee replacements.

- Vascular At-Risk – targets hypertension, hyperlipidemia and metabolic syndrome as precursors of vascular diseases.

MYHEALTH ADVANTAGE

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

MYHEALTH COACH

MyHealth Coach serves as a personal health guide for individuals and their families. Each coach provides education, counseling, tools and support to help You navigate the health care system and make wise decisions. MyHealth Coach is available if You are experiencing health issues or need assistance managing lifestyle issues. MyHealth Coach primarily uses the following:

- Coaching for education and self-care via web-based, self-help tools and the program's 24/7 NurseLine.
- Collaborative goal planning and intervention strategies with You.
- Facilitation, coordination and referral to necessary services.
- Incorporating clinical resources such as pharmacists, social workers and dietitians.
- Mailed and telephonic education, including healthy living support through the Healthwise Knowledgebase®.

The coach works with You and Your family to create an individualized program that features personalized goals to ensure You are following Your Provider's plan of care.

24/7 NURSELINE

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

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

ANTHEM'S LIVEHEALTH ONLINE

With LiveHealth Online, You don't even have to leave Your home or office for Your appointment. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed (as legally permitted in certain States).

You get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Help at the same cost as Your regular doctor visits.
- Private, secure and convenient Online Visits.

You can use LiveHealth Online whenever You have a health concern and don't want to wait. Doctors are available 24 hours a day, seven days a week, 365 days a year. Some of the most common uses are:

- Cold and flu symptoms such as cough, fever, and headaches
- Allergies
- Sinus infections
- Family health questions
- Behavior health services

AIM IMAGING COST & QUALITY PROGRAM

Sentry Insurance has selected this innovative Imaging Cost & Quality Program for Anthem Blue Cross Blue Shield Members through AIM Specialty Health. This Program provides You with access to important information about imaging services You might need. The Program is not a benefit under Your health benefit plan.

If You need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where You go to receive the service. Sometimes the differences are significant – anywhere from $300 to $3000 – but a higher price doesn't guarantee higher quality. If Your benefit plan requires You to pay a portion of this cost (like a Deductible or Coinsurance) where You go can make a very big difference to Your wallet.

That's where the AIM Imaging Cost & Quality Program comes in – AIM does the research for You and makes it available to help You find the right location for Your MRI or CT scan. Here's how the Program works:

- Your doctor refers You to a radiology provider for an MRI or CT scan
- AIM works with Your doctor to help make sure that You are receiving the right test – using evidence-based guidelines
- AIM also reviews the referral to see if there are other providers in Your area that are high quality but have a lower price than the one You were referred to
- If AIM finds another provider that meets the quality and price criteria, AIM will give You a call to let You know
- You have the choice – You can see the radiology provider Your doctor suggested OR You can choose to see a provider that AIM tells You about. AIM will even help You schedule an appointment with the new provider

The AIM Imaging Cost & Quality Program gives You the opportunity to reduce Your health care expenses (and those of Your Employer) by selecting high quality, lower cost providers or locations. No matter which provider You choose, there is no effect on Your health care benefits. We are bringing this Program to You to give You information that helps You to make informed choices about where to go when You need care.

SLEEP STUDY PROGRAM

Your Plan includes benefits for a Sleep Management Program, which is a program that helps Your doctor make better informed decisions about Your treatment. The Sleep Management Program includes outpatient and home sleep testing and therapy. If You require sleep testing, depending on Your medical Condition, You may be asked to complete the sleep study in Your home. Home sleep studies provide the added benefit of reflecting Your normal sleep pattern while sleeping in the comfort of Your own bed versus going to an outpatient Facility for the test.

As part of this program, You are required to get Precertification for:

- Home sleep tests (HST)
- In-lab sleep studies (polysomnography or PSG, a recording of behavior during sleep)
- Titration studies (to determine the exact pressure needed for treatment)
- Treatment orders for equipment, including positive airway pressure devices (APAP, CPAP, BPAP, ASV), oral devices and related supplies.

If You need ongoing treatment, we will review Your care quarterly to assure that medical criteria are met for coverage. Your equipment supplier or Your doctor will be required to provide periodic updates to ensure clinical appropriateness. Ongoing claim approval will depend partly on how You comply with the treatment Your doctor has ordered.

If You have questions about Your care, please talk with Your doctor. For questions about Your Plan or benefits, please call Member Service.

MUSCULOSKELETAL AND PAIN MANAGEMENT

The Musculoskeletal and Pain Management program can help You and Your doctor make the best decision so You can get the right care in the right place. As part of this new program, prior authorization will be required to help you understand the treatment options and requirements for Plan coverage before You have joint surgery or spinal pain treatment. If You have a musculoskeletal condition, Your doctor must contact Anthem before scheduling any of the following:

- Spine, hip, knee or shoulder joint surgery; and
- Spinal pain treatment, such as spinal pain injections, epidurals, nerve blocks, ablations, thermal destruction of the intervertebral disc or use of spinal stimulators.

Your doctor can contact Anthem through our Provider portal or by calling the number for Image/Cardio/Sleep/Genetic/Ortho on Your Identification Card. Here's what happens next:

1. Your treatment will be reviewed by orthopedic, neurosurgical and pain specialists using state-of-the-art clinical criteria and considering Your benefits.
2. The review may also include a phone call between one of our specialists and Your doctor to help determine the right test, the right treatment, and the right place for Your care.

After the review, Your doctor will talk to You about Your treatment options.

SYDNEY HEALTH

Discover a powerful and more personalized health app. View all Your benefits and access wellness tools to improve Your overall health with the Sydney Health app.

The Sydney Health mobile app works with You by guiding You to better overall health — and for You by bringing Your benefits and health information together in one convenient place. Sydney Health has everything You need to know about Your benefits, so You can make the most of them while taking care of Your health.

Working with You

- Reminding You about important preventive care needs
- Guiding You with insights based on Your history and changing health needs
- Empowering You with personalized tools to find and compare healthcare Providers and check costs

BEHAVIORAL HEALTH RESOURCE CENTER

Extra support can make a big difference when facing issues such as anxiety, depression, eating disorders, or substance use. Our caring experts will work with You at no extra cost to find treatment programs and arrange confidential counseling and support services 24/7 that meet Your individual and family needs.

Summary of benefits

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

Your health Plan is a Preferred Provider Organization (PPO) for all Members except residents of Wisconsin; Members residing in Wisconsin are part of a Point of Service (POS) plan. The Plan is divided into two sets of benefits: In-Network and Out-of-Network. If You choose an In-Network Provider, You will receive In-Network benefits. Members who are residents of Wisconsin must use the appropriate POS In-Network Provider in their respective states to receive In-Network benefits. Utilizing this method means You will not have to pay as much money; Your out-of-pocket expenses will be higher when You use Out-of-Network Providers.

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

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

NETWORK SERVICES

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

If You receive Covered Services from an Out-of-Network Provider after we failed to provide You with accurate information in our Provider Directory at www.anthem.com, or after we failed to respond to your telephone or web-based inquiry within the time required by Federal law, Covered Services will be covered at the Network level.

For services from an Out-of-Network Provider:

- There is no limit to what an Out-of-Network provider can charge;
- The Out-of-Network Provider may charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see Health Care Management – Precertification for more details.)

USE THE MOBILE APP TO CONNECT WITH US

As soon as You enroll in this Plan, You should download the mobile app. You can find details on how to do this at www.anthem.com. The goal is to make it easy for You to find answers to Your questions. You can chat with a representative live in the app or contact us at www.anthem.com.

HOW TO FIND A PROVIDER IN THE NETWORK

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

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

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

THE BLUECARD PROGRAM

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

Health care management: Precertification

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Summary Plan Description. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/place of care.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many multiple sources including medical policy and clinical guidelines, or Pharmacy and therapeutics guidelines. It may be decided that a service that was asked for is not Medically Necessary if You have not tried other treatments that are more cost effective. In-Network Providers are required to obtain prior authorization. You are required to obtain prior authorization for services from an Out-of-Network Provider. The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate.

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

Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides Your services are Medically Necessary. For benefits to be covered, on the date You get service:

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an Exclusion under Your Plan; and
5. You must not have exceeded any applicable limits under Your Plan.

TYPES OF REVIEWS

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date. You should request the Claims Administrator review Your Plan to determine if there is an exclusion for the service or treatment.
- **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Summary Plan Description.

  For admissions following Emergency Care, You, Your authorized representative or doctor should tell the Claims Administrator of the admission as soon as possible. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.
- **Continued Stay/Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

  Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.
- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage determination that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Failure to Obtain Precertification Penalty
If you or your non-network provider do not obtain the required precertification, the claim will be denied as not covered. Once information is received, claims can be re-opened based on medical information provided. This does not apply to medically necessary Inpatient Facility services from a network or BlueCard provider.

The following list is not all inclusive and is subject to change. Limitations and exclusions may apply depending on Your Plan's Covered Services. Please call the Member services telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

INPATIENT ADMISSION

- Acute Inpatient
- Acute Rehabilitation
- LTACH (Long Term Acute Care Hospital)
- Skilled Nursing Facility
- OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)

DIAGNOSTIC TESTING

- BRAC Genetic Testing
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability and Congenital Anomalies
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Gene Mutation Testing for Cancer Susceptibility and Management
- Genetic Testing for Inherited Diseases
- Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP) Attenuated FAP and MYH-Associated Polyposis
- Preimplantation Genetic Diagnosis Testing
- Prostate Saturation Biopsy
- Testing for Biochemical Markers for Alzheimer's Disease
- Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders

DURABLE MEDICAL EQUIPMENT (DME)/PROSTHETICS

- Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output
- Compression Devices for Lymphedema
- Electronic Tumor Treatment Field (TTF)
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- High Frequency Chest Compression Devices for Airway Clearance.
- Implantable Infusion Pumps
- Intrapulmonary Percussive Ventilation (IPV) Device
- Microprocessor Controlled Knee-Ankle-Foot Orthosis
- Microprocessor Controlled Lower Limb Prosthesis
- Myoelectric Upper Extremity Prosthetic Devices
- Noninvasive Electrical Bone Growth Stimulation of the Appendicular Skeleton
- Standing Frames
- Ultrasonic Diathermy Devices
- Ultrasound Bone Growth Stimulation
- Powered Wheeled Mobility Devices

GENDER-AFFIRMING SURGERY

HUMAN ORGAN AND BONE MARROW/STEM CELL TRANSPLANTS

- Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
    - Donor Leukocyte Infusion
    - Intrathecal treatment of Spinal Muscular Atrophy (SMA) Spinraza (nusinersen)
    - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
    - (CAR) T-cell immunotherapy treatment including but not limited to:

- Axicabtagene ciloleucel (Yescarta™)
    - Tisagenlecleucel (Kymriah™)
    - Brexucabtagene Autoleucel (Tecartus)
    - lisocabtagene maraleucel (Breyanzi)
    - idecabtagene vicleucel (Abecma)
    - Carvykti (ciltacabtagene autoleucel) (CAR-T)
- – Gene Replacement Therapy (Clear confirmation that the group has excluded the benefit is required. If the benefit is covered, Precertification is required). Including, but not limited to:
    - Gene Therapy for Ocular Conditions/ Voretigene neparvovec-rzyl (Luxturna™)
    - Gene Therapy for Spinal Muscular Atrophy/ onasemnogene abeparvovec-xioi (Zolgensma®)
    - Gene Therapy for Hemophilia
    - Gene Therapy for Beta Thalassemia Betibeglogene autotemcel (ZYNTEGLO)
    - Gene Therapy for Cerebral Adrenoleukodystrophy (CALD)

MENTAL HEALTH/SUBSTANCE USE Disorder (MH/SUD)

Pre-Certification Required

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Residential Care
- Mental Health in-home Programs
- Applied Behavioral Analysis (ABA)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)

OTHER OUTPATIENT AND SURGICAL SERVICES

- Aduhelm (aducanumab)
- Air and Water Ambulance (excludes 911 initiated emergency transport)
- Abdominoplasty and Panniculectomy
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Allogeneic, Xenographic, Synthetic Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting
    - Insertion/injection of prosthetic material collagen implants
- Axial Lumbar Interbody Fusion
- Balloon Sinus Ostial Dilation
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity
- Blepharoplasty, Blepharoptosis Repair, and Brow Lift
- Bone-Anchored and Bone Conduction Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, and other Breast Procedures
- Bronchial Thermoplasty
- Cardiac Contractility Modulation Therapy
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Cardioverter Defibrillator
- Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty
- Cervical and Thoracic Discography
- Cochlear Implants and Auditory Brainstem Implants
- Corneal Collagen Cross-Linking
- Cosmetic and Reconstructive Services: Skin Related, including but not limited to:
    - Brachioplasty
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Procedures Performed on the Face, Jaw, or Neck (including facial dermabrasion, scar revision)
- Cosmetic and Reconstructive Services of the Trunk and Groin, including but not limited to:
    - Brachioplasty
    - Buttock/Thigh Lift
    - Congenital Abnormalities
    - Lipectomy/Liposuction

- Repair of Pectus Excavatum/Carinatum
    - Procedures on the Genitalia
- Cosmetic and Reconstructive Services of the Head and Neck, including but not limited to:
    - Facial Plastic Surgery Otoplasty - Rhinophyma
    - Rhinoplasty or Rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)
    - Rhytidectomy (Face lift)
    - Cranial Nerve Procedures
    - Ear or Body Piercing
    - Frown Lines
    - Neck Tuck (Submental Lipectomy)
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems
- Doppler-Guided Transanal Hemorrhoidal Dearterialization (THD)
- Electrophysiology-Guided Noninvasive Stereotactic Cardiac Radioablation
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- Focal Laser Ablation for the Treatment of Prostate Cancer
- Functional Endoscopic Sinus Surgery (FESS)
- Home Parenteral Nutrition
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable Infusion Pumps
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Implanted Devices for Spinal Stenosis
- Implanted Artificial Iris Devices
- Implanted Port Delivery Systems to Treat Ocular Disease
- Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain
- Intracardiac Ischemia Monitoring
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Leadless Pacemaker
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia
- Mastectomy for Gynecomastia
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Meniscal Allograft Transplantation of the Knee
- Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis
- Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Partial Left Ventriculectomy
- Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
- Penile Prosthesis Implantation
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- Perirectal Spacers for Use During Prostate Radiotherapy)
- Photocoagulation of Macular Drusen
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing in the Home Setting

- Reduction Mammaplasty
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion, Open
- Self-Expanding Absorptive Sinus Ostial Dilation
- Sipuleucel-T (Provenge®) Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Surgical and Ablative Treatments for Chronic Headaches
- Therapeutic Apheresis
- Total Ankle Replacement
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins
- Transcatheter Heart Valve Procedures
- Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia, and Gastroparesis
- Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
- Treatment of Osteochondral Defects
- Treatment of Temporomandibular Disorders
- Treatment of Varicose Veins (Lower Extremities)
- Treatments for Urinary Incontinence
- Vagus Nerve Stimulation
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome and Varicocele
- Venous Angioplasty with or without Stent Placement/Venous Stenting
- Viscocanalostomy and Canaloplasty
- Wireless Cardiac Resynchronization Therapy for Left Ventricular Pacing
- Wearable Cardioverter-Defibrillator

OUT-OF-NETWORK REFERRALS:

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

RADIATION THERAPY/RADIOLOGY SERVICES

- Intensity Modulated Radiation Therapy (IMRT)
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Proton Beam Therapy
- Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule
- Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Lutathera, Pluvicto, Zevalin)
- Xofigo (Radium Ra 223 Dichloride)

Members may have benefit Plans with specialty services medically managed as part of a purchased program called Carelon Medical Benefits Management, which helps to ensure delivery of healthcare services that are more clinically appropriate, safer, and more affordable.

For more information, or to determine if preapproval is needed, contact the phone number on the back of Your Member Identification Card to verify Your benefits and ask about the Precertification process. To submit Your Precertification request for these services, call us at 866-714-1103.

Note: If any of the procedures listed below apply to You, Precertification is required. Remember to confirm Your benefits by calling the number on the back of Your Identification Card.

Specialty services may include:

Radiology Solution

The radiology solution helps reduce Members' exposure to unnecessary radiation by promoting evidence-based imaging practices. Our radiology solution reviews advanced imaging services, including CT/CTA, MRI/MRA, PET.

Sleep Solution

We partner with Providers through our sleep solution program to promote clinically appropriate testing and treatment for obstructive sleep apnea and other common sleep disorders. We also help manage treatment adherence and reduce unused treatment supplies.

Musculoskeletal and Pain Management Solution

The musculoskeletal solution manages some of the most common musculoskeletal treatments, like interventional pain management, joint surgery, and spinal surgery with both a clinical appropriateness review and level of care reviews.

Services not requiring pre-certification for coverage, but recommended for pre-determination of medical necessity due to the existence of post service claim edits and/or the potential cost of services to the member if denied by Anthem for lack of medical necessity:

Procedures, equipment, and/or specialty infusion drugs which have medically necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines

Notes

- This standard list applies to National Accounts licensed under Anthem Blue Cross, Anthem Blue Cross Blue Shield, Blue Cross Blue Shield of Georgia, Empire Blue Cross Blue Shield. A complete list of Medical Policies and Clinical Guidelines is available by visiting www.anthem.com and using the Provider tab for accessing information. You may also call the Customer Service number on the member ID card to see if the specific requested code is subject to medical policy or clinical guideline criteria.
- Utilizing a Provider outside of the Network may result in significant additional financial responsibility for You, because Your health benefit plan cannot prohibit Out-of-Network Providers from billing You for the difference between the Provider's charge and the benefit the Plan provides.
- The ordering Provider, Facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

WHO IS RESPONSIBLE FOR PRE-CERTIFICATION?

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

Provider Network Status	Responsibility to get Precertification	Comments
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, LA, ME, MO, NH, NV, NY, OH, VA, WI); Anthem Blue Cross (CA); Anthem Blue Cross Blue Shield (GA); and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company	Provider	The Provider must get Precertification when required

Blue Card Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed	Member (Except for Inpatient Admissions)	• Member must get Precertification when required or work with your Provider to assist in obtaining Precertification. Call Member Services at the number on the back of Your Identification Card. • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary, not an emergency, or any charges in excess of the Maximum Allowed Amount. • BlueCard Providers must obtain Precertification for all Inpatient admissions.

Note: For an Emergency Care admission, precertification is not required. However, You, Your authorized representative or doctor should tell the Claims Administrator as soon as You are stabilized.

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, Pharmacy and therapeutics guidelines, preventive care clinical coverage guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

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

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

DECISION AND NOTICE REQUIREMENTS

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

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request

Non-urgent Continued Stay/Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

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

The Claims Administrator will notify You and Your Provider of its decision as required by Federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

IMPORTANT INFORMATION

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

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

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

You may find out whether a Provider is taking part in certain programs or a provider arrangement by contacting the Member Services number on the back of Your Identification Card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

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

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

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

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

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

A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify You or Your authorized representative in writing.

Benefits

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

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

ALTERNATIVE BENEFITS

The Claims Administrator will consider alternative treatment plans proposed by or on behalf of a Covered Member when these expenses:

- Are in lieu of Covered Charges;
- Provide a cost-effective alternative to traditional treatment; and
- Enhance the well-being of the sick or injured Covered Member.

This provision will be offered only in accordance with a plan of alternative treatment with which the Covered Member (or the Covered Member's legal guardian) and the attending Physician concur, and it is approved by the Plan Administrator. The Plan Administrator has sole discretion to rescind or end the Plan's benefits for an alternative treatment plan and re-establish benefits under the Plan's normal terms.

AMBULANCE SERVICE

Medically Necessary Ambulance Services are a Covered Service when:

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

And one or more of the following criteria are met:

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

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

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

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

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

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

Other non-covered Ambulance Services include, but are not limited to:
- a Physician's office or clinic; or
- a morgue or funeral home.

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

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

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

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

MENTAL HEALTH CARE AND SUBSTANCE USE DISORDER TREATMENT
See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Mental Health Care and Substance Abuse Treatment on an Inpatient or outpatient basis will not be subject to Deductibles or Coinsurance/Copayment provisions that are less favorable than the Deductible or Coinsurance/Copayment provisions that apply to a physical illness as covered under this Summary Plan Description.

Covered Services include the following:
- Inpatient Services in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.
- Residential Treatment in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - Observation and assessment by a psychiatrist weekly or more often; and
  - Rehabilitation and therapy
- Outpatient Services including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs;
- Online Visits (including Telehealth) when available in Your area. Covered Services include a medical visit with the doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to doctor discussions. Online visits (including Telehealth) are not covered from Providers other than those contracted with LiveHealth Online.

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

BREAST RECONSTRUCTIVE SURGERY

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

CARDIAC REHABILITATION

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

CELLULAR AND GENE THERAPY SERVICES

Your Plan includes benefits for cellular and gene therapy services when Anthem approves the benefits in advance through Precertification. Please refer to the Healthcare Management - Precertification section for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is a Network Provider for other services it may not be an approved Provider for certain cellular and gene therapy services. Please call us to find out which Providers are approved Providers.

SERVICES NOT ELIGIBLE FOR COVERAGE

Your Plan does not include benefits for the following:

a. Services determined to be Experimental/Investigational;
b. Services provided by a non-approved Provider or at a non-approved Facility; or
c. Services not approved in advance through Precertification.

CLINICAL TRIALS

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

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

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

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

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

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

COLONOSCOPY

Colonoscopy charges are covered subject to Deductible and Coinsurance.

CONSULTATION SERVICES

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

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

DENTAL SERVICES

Related to Accidental Injury

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

DIABETES

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

DIALYSIS TREATMENT

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

DURABLE MEDICAL EQUIPMENT (DME), MEDICAL DEVICES AND SUPPLIES

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

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

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

EMERGENCY SERVICES

Life-threatening Medical Emergency or Serious Accidental Injury

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

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Medically Necessary services will be covered whether You get care from a Network or Out-of-Network Provider. Emergency Care You get from an Out-of-Network Provider will be covered as a Network service and will not require Precertification. Your cost shares will be based on the Maximum Allowed Amount and will be applied to Your Network Deductible and Network Out-of-Pocket Limit.

Treatment You get after your condition has stabilized is not Emergency Care.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan Network contract rate we pay Network Providers for the geographic area where the service is provided.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the Schedule of Benefits.

GENERAL ANESTHESIA SERVICES

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

- Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:
- Spinal or regional anesthesia;
- Injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

HABILITATIVE SERVICES

Benefits also include habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with impairments in a variety of Inpatient and/or outpatient settings.

HOME HEALTH CARE SERVICES

Home Health Care provides a program for the Member’s care and treatment in the home. Your coverage is outlined in the Schedule of Benefits. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member’s attending Physician. Services may be performed by either Network or Out-of-Network Providers. The Physician’s statement and recommended program may require Precertification. Please refer to the Healthcare Management-Precertification section for details.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member’s illness.

- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:
- Food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- Services and/or supplies which are not included in the Home Health Care plan as described;
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse;
- Any services for any period during which the Member is not under the continuing care of a Physician;
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member;
- Any services or supplies not specifically listed as Covered Services;
- Routine care and/or examination of a newborn child;
- Dietician services;
- Hemodialysis treatment; or
- Purchase or rental of dialysis equipment.

HOSPICE CARE SERVICES

You are eligible for Hospice care if Your doctor and the Hospice medical director certify that You are terminally ill and likely to have less than twelve (12) months to live. You may access Hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:
- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- Social services and counseling services from a licensed social worker;
- Nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties for one year after the Member's death.

Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to, chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Summary Plan Description.

HOSPITAL SERVICES

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

In-Network Inpatient Services
- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the

Hospital's prevalent semiprivate rate. If You are admitted to Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

In-Network Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

In-Network Length of Stay

- Determined by Medical Necessity

Out-of-Network

- Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the Schedule of Benefits section.

HOSPITAL VISITS

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

Your Plan includes coverage for Medically Necessary human organ and tissue transplants.

Covered Procedures

Covered procedures as approved by the Claims Administrator include:

- Any Medically Necessary human solid organ, tissue, and stem cell/bone marrow transplants and infusions; and
- 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.

Notification

To maximize Your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work up services must be provided by a Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are Network Transplant Providers.

Centers of Medical Excellence (CME) Transplant Providers

Blue Distinction Center Facility: Blue Distinction Facilities have met or exceeded national quality standards for care delivery.

Centers of Medical Excellence (CME): Centers of Medical Excellence Facilities have met or exceeded quality standards for care delivery.

Network Transplant Provider: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to You and take care of certain administrative duties for the Transplant Network. A Provider may be a Network Transplant Provider for certain covered Transplant Procedures or all covered Transplant Procedures.

Out-of-Network (PAR) Transplant Provider: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.

Contact the Member Services telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or Summary Plan Description exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period
At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Solid Organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a Covered Bone Marrow/Stem Cell Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts the day of a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification
In order to maximize Your benefits, the Claims Administrator strongly encourages You to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Member Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting. Your Provider must certify, and the Claims Administrator must agree that the covered procedure is Medically Necessary. Not getting Precertification will result in a denial of benefits.

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

Transportation and Lodging
The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the Facility where Your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

LICENSED SPEECH THERAPIST SERVICES

Services must be ordered and supervised by a Physician as outlined in the Schedule of Benefits. Speech therapy is not covered when rendered for the treatment of Developmental Delay.

MATERNITY CARE & REPRODUCTIVE HEALTH SERVICES

Covered Services are provided for Network Maternity Care as stated in the Schedule of Benefits. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the Schedule of Benefits.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.)

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member's attending Physician.

Abortion (Therapeutic or Elective)
Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape. Your Plan also provides benefits for an elective (voluntary) abortion, which is an abortion performed for reasons other than those described above.

Contraceptive Benefits
Benefits include oral contraceptive Drugs, injectable, contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs) and implants. Certain contraceptives are covered under the "Preventive Services" benefit. Please see that section for further details.

Infertility Services
Your Plan also includes benefits for the diagnosis and treatment of Infertility. Covered Services include diagnostic and exploratory procedures to determine whether a Member suffers from Infertility. This includes surgical procedures to correct a diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. Covered fertilization services include artificial insemination, in-vitro fertilization, GIFT (gamete intra-fallopian transfer), or ZIFT (zygote intra-fallopian transfer) procedures. See the Schedule of Benefits for benefit limitations, Coinsurance and Copayment amounts.

Sterilization Services
Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Services" benefit.

MEDICAL CARE

General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

NUTRITIONAL COUNSELING FOR DIABETES

Nutritional counseling related to the medical management of a disease state as stated in the Schedule of Benefits.

OBESITY

Prescription Drugs and any other services or supplies for the treatment of obesity are not covered.

OUT-OF-NETWORK FREESTANDING AMBULATORY FACILITY

Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

OUT-OF-NETWORK HOSPITAL BENEFITS

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the Schedule of Benefits section.

ONLINE VISITS (TELEHEALTH)

Please refer to Virtual Visits later in this section.

ORAL SURGERY

Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;

- Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan.

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral/surgical correction of accidental injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

OTHER COVERED SERVICES

Your Plan provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- Diagnostic x-ray and laboratory procedures;
- Dressings, splints and casts when provided by a Physician;
- Oxygen, blood and components, and administration;
- Pacemakers and electrodes; or
- Use of operating and treatment rooms and equipment.

OUT-OF-NETWORK FREESTANDING AMBULATORY SURGERY CENTER

Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Surgery Center will be payable at the Maximum Allowed Amount.

OUTPATIENT CT SCANS AND MRIS

These services are covered at regular Plan benefits.

OUTPATIENT HOSPITAL SERVICES

The Plan provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

OUTPATIENT SURGERY

Network Hospital outpatient department or Network Freestanding Ambulatory Surgery Center charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services.”

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, MANIPULATION THERAPY

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.) or a licensed chiropractor (D.C.) as outlined in the Schedule of Benefits. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No coverage is available when such services are necessitated by Developmental Delay.

PHYSICIAN SERVICES

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements. Consultations between your Primary Care Physician and a Specialty Care Physician are included, when approved by the Claims Administrator.

PRESCRIPTION DRUG BENEFITS

Benefits for medically necessary Prescription Drugs for treatment of an Injury or sickness are provided by Express Scripts. Refer to the Prescription Benefits section of this Summary Plan Description (SPD) for details.

PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER

Your Plan covers Prescription Drugs when they are administered to You as part of a doctor's visit, home care visit, or at an outpatient facility when they are Covered Services. This may include drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when Your Provider orders the drug and administers it to You in a medical setting. Benefits for drugs that You inject or get at a Pharmacy (i.e., self-administered injectable drugs) are not covered under this section. See the Prescription Benefits section of this SPD for more information.

Note
When Prescription Drugs are covered under the medical Plan, they will not also be covered under the prescription Plan. Also, if Prescription Drugs are covered under the prescription Plan, they will not also be covered under the medical Plan.

Prescription Drugs
To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under Federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider, and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound Drugs are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound Drug are FDA approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and are not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Important Details About Prescription Drug Coverage
Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing doctor may be asked to give more details before the Plan decides if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy, requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem Prescription Drug List (a formulary developed by the Claims Administrator which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost-effectiveness.

Precertification
Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will give the results of the Plan's decision to both You and Your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of Your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section Health Care Management – Precertification for more details.

If precertification is denied You have the right to file an appeal as outlined in the Your Right to Appeal section of this Summary Plan Description.

Designated Pharmacy Provider
The Plan in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider's office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider's office.

You may also be required to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. The Plan reserves the right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. The Plan may from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in the Plan's discretion, such change can help provide cost-effective, value based and/or quality services. If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level. You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at www.anthem.com.

Therapeutic Substitution
Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed Drugs. The Claims Administrator may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of Your Identification Card.

PREVENTIVE CARE
Preventive Services include screenings and other services for adults and children. All recommended preventive services according to the Affordable Care Act (ACA) will be covered subject to your deductible and coinsurance.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under diagnostic services instead of this benefit, if the coverage does not fall within ACA-recommended preventive services.

Covered Services fall under the following broad groups:
1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    a. Breast cancer;
    b. Cervical cancer;
    c. Colorectal cancer;
    d. High blood pressure;
    e. Type 2 Diabetes Mellitus;
    f. Cholesterol
    g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
    a. Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Some categories and classes of contraceptives do not have Generic Drugs available and, in each of these categories, at least one Brand Drug is available at $0 cost-sharing when You receive it from a Network Provider. If Your Provider determines that a Brand Drug with an available generic therapeutic equivalent is Medically Necessary because a generic equivalent Drug is not appropriate for You, You may obtain coverage of the Brand Drug with $0 cost-sharing if Your Provider submits an exception request. Your Provider must complete a contraceptive exception form and return it to the Claims Administrator. You or Your

Provider can find the form online at https://file.anthem.com/Anthem_ABS_BrandContraceptiveCopayWaiverForm.pdf, or by calling the number on the back of Your Identification Card. If Medical Necessity has been determined by Your Provider, an exception will be granted and coverage of the Drug will be provided at $0 cost-sharing
   b. Breastfeeding support, supplies and counseling.
   c. Gestational diabetes screening.
5. Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
   a. Counseling;
   b. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy; when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

You may call Member Services using the number on Your Identification Card for additional information about these services or view the Federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html, http://.ahrq.gov and http://www.cdc.gov/vaccines/acip/index.html.

PROSTHETIC APPLIANCES

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens of the eye(s); arm braces; leg braces (and attached shoes); and external breast prostheses used after breast removal.

Benefits include hearing aids for adults, including FDA-approved over-the-counter hearing aids (a Prescription is required), when Members have been certified as deaf or hearing-impaired by a Physician or licensed audiologist.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth (except to correct traumatic Injuries); electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

RECONSTRUCTIVE SURGERY

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, Injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.

Note: Coverage for reconstructive services does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

RETAIL HEALTH CLINIC

Benefits are provided for Covered Services received at a Retail Health Clinic.

SKILLED NURSING FACILITY CARE

Benefits are provided as outlined in the Schedule of Benefits. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or Facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and radiology;
- Physical or speech therapy;

- Oxygen and other gas therapy;
- Drugs and solutions used while a patient; or
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24 hour-a-day nursing care.

Benefits will not be provided when:
- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24 hour-a-day nursing service;
- No specific medical conditions exist that require care in a Skilled Nursing Facility; or
- The care rendered is for other than Skilled Convalescent Care.

SURGICAL CARE
Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

TREATMENT OF ACCIDENTAL INJURY IN A PHYSICIAN'S OFFICE
All outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit if services are rendered by a Network Provider. Services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

VIRTUAL VISITS
When available in Your area, Your coverage will include Virtual Visits. Covered Services include virtual Telemedicine/Telehealth visits, appropriately provided through the internet via video. This includes visits with Providers who offer services in person in addition to virtual care-only.. Please refer to "Physician Services" in the Schedule of Benefits section for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information. For mental health and substance abuse Virtual Visits, please refer to "Mental Healthcare and Substance Abuse Treatment" in the Schedule of Benefits section. Non-Covered Services include, but are not limited to, communications used for:
- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage, or payment questions
- Requests for referrals to Physicians outside of the online care panel
- Benefit Precertification
- Physician-to-Physician consultation.

Limitations and exclusions

These limitations and exclusions apply even if a qualified practitioner has performed or prescribed a Medically Necessary procedure, treatment or supply. This does not prevent Your qualified practitioner from providing or performing the procedure, treatment or supply. Regardless, the procedure, treatment or supply will not be a covered expense.

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military Facilities except as required by law.
2. Services for Custodial Care.
3. Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.
4. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
5. Charges for treatment received before coverage under this option began or after it is terminated.
6. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated.
7. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.
8. Foot care only to improve comfort or appearance, routine care of corns, calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
9. Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary).
10. Treatment where payment is made by any local, state, or Federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
11. Medicare – For which benefits are payable under Medicare Parts A and/or B or would have been payable if You had applied for Parts A and/or B, except as listed in this Benefit Booklet or as required by Federal law, as described in the section titled "Medicare" in **General Information**. If You do not enroll in Medicare Part B when You are eligible, You may have large Out-of-Pocket costs. Please refer to Medicare.gov for more details on when You should enroll and when You are allowed to delay enrollment without penalties.
12. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
13. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.
14. Outpatient prescription drugs prescribed by a Physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Although coverage for outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under Your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in Your Physician's office.
15. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
16. Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

17. Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary.
18. Services for Hospital confinement primarily for diagnostic studies.
19. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an injury or to correct a congenital defect.
20. Donor Search/Compatibility, except as otherwise indicated.
21. Contraceptive Drugs, except for any above stated covered contraceptive devices.
22. In-vitro Fertilization, Artificial Insemination and as indicated on the Plan Design.
23. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
24. Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this Benefit Booklet.
25. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
26. Christian Science practitioner services.
27. Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law.
28. Services provided in a halfway house.
29. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state or Federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.
30. Routine care is not covered. Except for above stated covered preventive care services.
31. Services or supplies provided by a member of Your family or household.
32. Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator.
33. Fees or charges made by an individual, agency or Facility operating beyond the scope of its license.
34. Services and supplies for which You have no legal obligation to pay, or for which no charge has been made or would be made if You had no health insurance coverage.
35. Charges for any of the following:
    a. Failure to keep a scheduled visit;
    b. Completion of claim forms or medical records or reports unless otherwise required by law;
    c. For Physician or Hospital's stand-by services;
    d. For holiday or overtime rates.
    e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
    f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
36. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered Facility, which makes their services available.
37. Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses and/or take-home supplies.
38. Reversal of vasectomy or reversal of tubal ligation.
39. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes and/or which are performed as a treatment for acne.
40. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.
41. Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices

to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e. diabetes.

42. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
43. Services for weight loss programs, services and supplies. Weight loss programs include, but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss).
44. Non-Approved Facility - Services from a Provider at a facility that does not meet the definition of Facility.
45. Hearing aids, hearing devices or examinations for prescribing or fitting them.

Claims payment

In-Network Providers have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore, if the In-Network Hospitals, Physicians and Ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the Provider requests a claim form to file a claim, a claim form can be obtained by contacting Your Human Resources Department, or by visiting www.anthem.com.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign Providers from sending Your claims and other personal information to the Claims Administrator.

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

HOW TO FILE CLAIMS

Under normal conditions, the Claims Administrator should receive the proper claim form within 12 months after the service was provided. This section of the Summary Plan Description describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan. Residents of Wisconsin must use POS Network Providers.

When You receive Covered Services from a Network physician or other Network licensed health care Provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the Provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from Your Employer or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

MAXIMUM ALLOWED AMOUNT

General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the "Inter-Plan Arrangements" section for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- That meet the Plan's definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from an Out-of-

Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER IN-NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Medical Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers.

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established at its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Provider's fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider; or
6. An amount as required by applicable state law.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers

will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated price.

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

Member Services is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

MEMBER COST SHARE

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

Your cost share amount and Out-of-Pocket Maximums may vary depending on whether You received services from an In-Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this Summary Plan Description for Your cost share responsibilities and limitations, or call Member Service to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

The Plan will not provide any reimbursement for Non-Covered Services. You may be responsible for the total amount billed by Your Provider for Non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Summary Plan Description and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

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

SERVICES PERFORMED DURING SAME SESSION

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

PROCESSING YOUR CLAIM

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

TIMELINESS OF FILING-MEMBER SUBMITTED CLAIMS

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of

the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

NECESSARY INFORMATION

In order to process Your claim, the Claims Administrator may need information from the Provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other Provider to release necessary information. The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

FEDERAL/STATE TAXES/SURCHARGES/FEES

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

CLAIMS REVIEW

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

NOTICE OF CLAIM & PROOF OF LOSS

After You get Covered Services, we must receive written notice of Your claim within 12 months in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within 12 months or no benefits will be covered, unless otherwise required by law (e.g., Federal law allows exceptions for claims filed by the Veteran's Administration up to a maximum 6 years from the date of service).

MEMBER'S COOPERATION

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If You fail to cooperate (including if You fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), You will be responsible for any charge for services.

EXPLANATION OF BENEFITS

After You receive medical care, You will generally receive and Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

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

INTER-PLAN PROGRAMS

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area the Claims Administrator serves (the Anthem "Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Anthem Service Area, You will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating Providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

Inter-Plan arrangements eligibility – Claim types
Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program
Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, the Claims Administrator will still fulfill its contractual obligations. But, the Host Blue is responsible for (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard® Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for Your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements
With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process Your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special cases: Value-based programs
BlueCard® Program
If You receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-based programs: Negotiated (non-BlueCard Program) arrangements
If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Employer on Your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan programs: Federal/state taxes/surcharges/fees
Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

E. Nonparticipating Providers outside the Claims Administrator's service area

1. **Allowed Amounts and Member Liability Calculation**
   When Covered Services are provided outside of Anthem's Service Area by non-participating Providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or Federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating 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.
2. **Exceptions**
   In certain situations, the Plan may use other pricing methods, such as billed charges or the pricing the Plan would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated

price to determine the amount the Plan will pay for services provided by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Plan make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core® Program

If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health Identification Card with You.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

If You need Inpatient hospital care, You or someone on Your behalf, should contact the Claims Administrator for preauthorization. Keep in mind, if You need Emergency medical care, go to the nearest hospital. There is no need to call before You receive care.

Please refer to the Health Care Management – Precertification section in this Booklet for further information. You can learn how to get preauthorization when You need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when You arrange Inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will find the address for mailing the claim on the form.

When You need Blue Cross Blue Shield Global Core® claim forms You can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at bcbsglobalcore.com

You will find the address for mailing the claim on the form.

NON-PARTICIPATING HEALTHCARE PROVIDERS OUTSIDE ANTHEM'S SERVICE AREA

Member Liability Calculation

When covered healthcare services are provided outside of the Claims Administrator's Service Area by non-participating healthcare providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable State law. In these situations, You may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Administrator would make if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Administrator will pay for services rendered by nonparticipating healthcare providers. In these situations, You may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

If You obtain services in a State with more than one Blue Plan Network, an exclusive network arrangement may be in place. If You see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Out-of-Network care, and You may be billed the difference between the charge and the Maximum

Allowable Amount. You may call the Member Service number on Your ID card or go to www.anthem.com for more information about such arrangements.

UNAUTHORIZED USE OF IDENTIFICATION CARD

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

ASSIGNMENT

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to You as opposed to any Provider for Covered Service. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or You) will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA, if subject to ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted. The coverage and any benefits under the Plan are not assignable by any Member without written consent of the Plan, except as provided above.

AUTHORIZED SERVICES

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost-share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider (this is referred to as "In-For-Out Benefit Treatment"). In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service in order to get approval for In-For-Out Benefit Treatment. If the Plan authorizes a Network cost-share amount for Non-Emergency Care for Covered Services provided by an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless Your claim involves a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

BALANCE BILLING

In-Network Physicians are prohibited from balance billing. An In-Network Provider has signed an agreement with the Claims Administrator, to accept an agreed upon fee, negotiated rate or Maximum Allowed Amount for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee except what is due under the Plan, e.g., Copayments, Deductibles or Coinsurance.

If You go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, You will be responsible for the In-Network cost share amount (Coinsurance or Copayment). This is because You did not have a choice in selecting the Provider employed by or contracted with the Hospital or Facility.

If You choose to receive Covered Services from an Out-of-Network Physician, when You could have selected an In-Network Physician, You will be responsible for the Out-of-Network cost share amount (Coinsurance or Copayment),

and responsible to pay the difference between the Out-of-Network Maximum Allowed Amount and the amount the Out-of-Network Physician charges.

QUESTIONS ABOUT COVERAGE OR CLAIMS

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Member Services Department. Be sure to always give Your Member identification number. When asking about a claim, give the following information:

- Identification number;
- Patient's name and address;
- Date of service and type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call the Claims Administrator. The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by an employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding. Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of Your new address.

Your right to appeal

The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. In those cases, please contact Member Services by calling the number on the back of Your Identification Card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of Your complaint, You have the right to file an appeal, which is defined as follows:

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

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

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

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

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable Federal regulations.

NOTICE OF ADVERSE BENEFIT DETERMINATION

If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- Information sufficient to identify the claim involved;
- The specific reason(s) for the denial;
- A reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- A description of any additional material or information needed to perfect Your claim;
- An explanation of why the additional material or information is needed;
- A description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA, if this Plan is subject to ERISA, within one year of the grievance or appeal decision if you submit a grievance or appeal and the claim denial is upheld;
- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- Information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision; and,
- Information regarding Your potential right to an External Appeal pursuant to Federal law.

For claims involving urgent/concurrent care:

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

APPEALS

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

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

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

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

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., Urgent Care). You or Your authorized representative must submit a request for review to:

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

You must include Your Member identification number when submitting an appeal.

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

- Was relied on in making the benefit determination; or
- Was submitted, considered, or produced in the course of making the benefit determination; or
- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly situated claimants; or
- Is a statement of the plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

The Claims Administrator will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an adverse benefit determination or review based on a new or additional rationale, the Claims Administrator will provide You, free of charge, with the rationale.

How Your Appeal will be Decided

When the Claims Administrator considers Your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

NOTIFICATION OF THE OUTCOME OF THE APPEAL

If You appeal a claim involving urgent/concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

If You appeal a post-service claim, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

APPEAL DENIAL

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

If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

VOLUNTARY SECOND LEVEL APPEALS

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

EXTERNAL REVIEW

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

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal. However, You are encouraged to submit any additional information that You think is important for review.

For pre-service claims involving urgent/concurrent care, You may proceed with an expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To proceed with an expedited External Review, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

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

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

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

You must include Your Member identification number when submitting an appeal.

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

REQUIREMENT TO FILE AN APPEAL BEFORE FILING A LAWSUIT

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

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

PLAN ADMINISTRATOR APPEAL

If You are dissatisfied with the Claims Administrator's appeal decisions, a voluntary appeal to the Plan Administrator may be available. If You would like to initiate an appeal to the Plan Administrator, please write to the address listed below. Voluntary appeals must be submitted within 60 calendar days from the denial of the last appeal through the Claims Administrator. You are not required to complete a voluntary third level appeal prior to submitting a request for an independent external review.

Plan Administrator:
Sentry Insurance Company
Attn: Chief Human Resources Officer
1800 North Point Drive
Stevens Point, WI 54481
Phone: 715-346-6550

You must exhaust the appeal options available through the Claims Administrator prior to submitting an appeal to the Plan Administrator.

Coordination of benefits (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Summary Plan Description, e.g., Plan. For this provision only, “Plan” will have the meanings as specified below. In the rest of the Summary Plan Description, Plan has the meaning listed in the Definitions section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans’ allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans’ allowable amounts. This higher allowable amount may be more than the Plan’s Maximum Allowed Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes Group and non group insurance contracts and subscriber contracts; Health Maintenance Organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or non group closed panel plans; group-type contracts; medical care components of long term care contracts such as skilled nursing care, medical benefits under group or individual automobile contracts (whether “fault” or “no fault”); other governmental benefits, except for Medicare, Medicaid or government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.
2. Plan does not include: Accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or “to and from school” basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or

in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non-Allowable expenses:
1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan’s payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan’s payment arrangement and if the Provider’s contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because You have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary high Deductible health plan’s Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

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

ORDER OF BENEFIT DETERMINATION RULES
When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
1. Except as provided Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

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

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 – Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an Employee, Member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an Employee, Member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 – Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than on Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the custodial parent;
        - The Plan covering the Spouse of the custodial parent;
        - The Plan covering the non-custodial parent; and then,
        - The Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of items 1. or 2. above will determine the order of benefits as if those individuals were the parents of the child.
4. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouses plan, Rule 5 applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule in item 1. above to the Dependent child's parent(s) and the Dependent's spouse.

Rule 3 – Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active Employee, that is, an Employee who is neither laid-off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off Employee is the Secondary Plan. The same would hold true if You are a Dependent of an active Employee and You are a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 – Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 – COBRA. If You are covered under COBRA or under a right of continuation provided by other Federal law and are covered under another Plan, the Plan covering You as an Employee, Member, subscriber or retiree or covering You as a Dependent of an Employee, Member, subscriber or retiree is the Primary Plan and the COBRA or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 – Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non-Dependent under both Plans (i.e., the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an Employee or as a retired Employee and is covered under his or her own Plan as an Employee, Member, subscriber or retiree); or (b) as a Dependent under both plans (i.e., the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as Dependent of an Employee Member or, Member, subscriber or retired Employee and is covered under the other plan as a Dependent of an Employee, Member, subscriber or retiree).

Rule 5 – Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6 – If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

SECONDARY TO OTHER COVERAGE

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

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan Deductible any amount it would have credited to its Deductible in the absence of other health care coverage.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel Plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. The Plan has paid or for whom the Plan have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

WHEN A COVERED PERSON QUALIFIES FOR MEDICARE

Determining which Plan is primary

To the extent permitted by law, this Plan will pay benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older, and
- Individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable expense, as long as the Provider accepts Medicare.. If the Provider does not accept Medicare, the Medicare limiting charge (the most a

Provider can charge You if they don't accept Medicare) will be the Allowable expense. Medicare payments, combined with Plan benefits, will not exceed 100% of the total Allowable expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.

Subrogation and reimbursement

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

DEFINITIONS

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

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

SUBROGATION

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

REIMBURSEMENT

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

SECONDARY TO OTHER COVERAGE

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

ASSIGNMENT

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

APPLICABILITY TO ALL SETTLEMENTS AND JUDGMENTS

Notwithstanding any allocation or designation of Your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full Recovery, in first priority, against any Recovery

You make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to Your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full Recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to Your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

CONSTRUCTIVE TRUST

By accepting benefits from the Plan, You agree that if You receive any payment as a result of an Injury, illness or condition, You will serve as a constructive trustee over those funds. You and Your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

LIEN RIGHTS

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

FIRST-PRIORITY CLAIM

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

COOPERATION

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

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal Injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal Injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.

- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or Recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

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

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

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

You acknowledge the Plan has the right to conduct an investigation regarding the Injury, illness or condition to identify potential sources of Recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge the Plan has notified You that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share Your personal health information in exercising these Subrogation and Reimbursement provisions.

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

DISCRETION

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

Prescription benefits

If You are a participant in the Sentry Retiree Medical Plan – Plus Option You are automatically enrolled in Prescription Drug coverage. The coverage is provided through Express Scripts, Inc. (the prescription Claims Administrator). Express Scripts has been designated by Your Employer to provide Prescription Drug administrative services for the Employer's Group Health Plan, such as claims processing, care management, and other services, and to arrange for a Network of Prescription Drug Providers.

This Summary Plan Description (SPD) provides details about the Prescription Drug benefits available to You through Express Scripts, including covered services, services that are not covered, and limitations and exclusions that apply.

With this Plan, Your cost is lower for generic and preferred brand-name Prescription Drugs. Express Scripts has contracts with most chain and independent Pharmacies nationwide.

How the prescription coverage works

The Plan offers In-Network and Out-of-Network coverage. The Plan Copayments are the same for In-Network and Out-of-Network Pharmacies. If you fill a Prescription Drug at an Out-of-Network Pharmacy, you must pay for the Prescription Drug out-of-pocket and you may submit a manual claim form to obtain reimbursement from the Plan.

PRESCRIPTION DRUG COPAYMENTS

For each Prescription Drug, You are responsible for a Copayment and/or percentage of the cost. The Copayments are different depending if You're eligible for Medicare. To estimate the cost of a Prescription Drug, login to Your personal account on express-scripts.com and use the Price a Medication tool.

Pre-Medicare Retirees – Copays apply immediately

Type of prescription drug	Generic	Preferred brand	Non-preferred brand
Retail Pharmacy (30-day supply)	$10	25% of cost (min $35; max $85)	50% of cost (min $60; max $120)
Home delivery (90-day supply)	$25	25% of cost (min $87.50; max $212.50)	50% of cost (min $150; max $300)

If You're pre-Medicare, Your out-of-pocket costs for prescriptions apply to a separate Prescription Drug Out-of-Pocket Maximum, which is $2,500 per person, maximum $5,000 per family. Once your Prescription Drug out-of-pocket costs satisfy the Prescription Drug Out-of-Pocket Maximum, Your covered prescriptions can be filled at no additional charge to You for the remainder of the calendar year.

Post-Medicare Retirees – Cost of Prescription Drugs subject to a $100 per person Prescription Drug Deductible, then:

Type of prescription drug	Generic	Preferred brand	Non-preferred brand
Retail Pharmacy (30-day supply)	$15	$50	$75
Home delivery (90-day supply)	$37.50	$125	$187.50

YOUR IDENTIFICATION CARD

Your Prescription Drug coverage information is located on Your Express Scripts Member Identification Card. If You need additional cards, You can request them by calling 844-536-9187.

EXPRESS SCRIPTS MOBILE APP

Download the Express Scripts mobile app to:

- Set up and manage home delivery of Your prescriptions
- Refill and renew Your prescriptions
- See Your order status, claims, and payment history
- Find and compare prices with Price a Medication

WHEN YOU NEED TO FILL A PRESCRIPTION

When You need to fill a prescription, You can choose to go to Your local participating In-Network retail Pharmacy or, for home delivery, use the Express Scripts Pharmacy. To find an In-Network retail Pharmacy or to learn how to set up home delivery with Express Scripts, login to Your personal account on express-scripts.com or call the Express Scripts Member Services number on Your Identification Card.

If Your Prescription Drug is for a one-time 30-day supply of a medication or less, the In-Network retail option is best.

If You are filling a long-term maintenance medication (one that You need for more than 60 days), You can fill it two times at a Pharmacy at the retail Pharmacy Copayment. The third fill, and every refill thereafter, will be subject to an additional $10 Copay penalty in addition to the Plan Copay. To avoid paying this penalty, You can switch Your maintenance (long-term) medication to Express Scripts' home delivery.

Regardless of whether You choose a local retail Pharmacy or the Express Scripts home delivery, generic drugs are used to fill prescriptions whenever possible unless Your doctor specifies otherwise. The pharmacist may contact Your doctor to suggest that a preferred brand-name drug be substituted with a comparable drug from Express Scripts' formulary list. Your doctor decides whether to switch to the formulary medication.

Concurrent Drug Utilization Review

Express Scripts' Concurrent/Prospective Drug Utilization Review (DUR) is a health and safety program that performs online, real-time drug utilization analysis at the point of prescription dispensing to evaluate the incoming therapy against a series of predetermined safety standards.

EXPRESS SCRIPTS SPECIALTY PHARMACY SERVICES

Specialty medications are drugs that are used to treat complex conditions such as cancer, growth disorders, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Accredo Health Group, Inc. ("Accredo"), an Express Scripts specialty pharmacy, is composed of therapy-specific teams that provide an enhanced level of individual service to patients with special therapy needs. Accredo provides You with:

- 24/7 access to pharmacists and nurses who have specialized training
- Ancillary supplies like syringes and sharps containers
- Careful handling of Your medicine and arranging a delivery time frame that works with Your schedule
- Monitor Your overall drug therapy and reminder calls when it's time to order refills

For more information, contact Accredo at 877-895-9697.

RETAIL PHARMACIES

Retail Pharmacies in the Express Scripts network are referred to as "In-Network" and "participating Pharmacies." To locate a participating Pharmacy close to Your home or other location, You can call Express Scripts Member Services number on Your Identification Card or login to Your personal account on express-scripts.com.

EXPRESS SCRIPTS PHARMACY FOR HOME DELIVERY

Home delivery adds convenience and cost savings to Your Prescription Drug benefits. You'll receive a 90-day supply of Your Prescription Drug at Your home, and You'll save money.

Home delivery is ideal for maintenance (long-term) Prescription Drugs that You take regularly for ongoing conditions such as high blood pressure, diabetes, and high cholesterol. These Prescription Drugs can be filled two times at a retail Pharmacy at the retail Pharmacy Copayment. However, the third fill at a retail Pharmacy, and every refill thereafter, will be subject to an additional $10 Copay penalty in addition to the Plan Copay. You can avoid the penalty Copay by switching Your Prescription Drug to home delivery.

To get started, log in to Your personal account on express-scripts.com to download the home delivery form or call the Express Scripts Member Services number on Your Identification Card.

PRESCRIPTION DRUG COORDINATION OF BENEFITS

The Prescription Drug benefit does not coordinate benefits with another Prescription Drug Plan.

Covered Prescriptions

The Express Scripts Prescription Drug coverage provides coverage for federal legend drugs which are drug products bearing the legend, "Caution: Federal law prohibits dispensing without a prescription." The Plan also covers certain Prescription Drug supplies, oral contraceptives, and some compound medications which contain at least one federal legend drug in a therapeutic amount.

For the Express Scripts Prescription Drug coverage to cover a prescription, the prescribed item must meet the following requirements:

- It must be a Prescription Drug written by a licensed physician and not have exceeded the accepted date range of validity. Prescriptions for all drugs other than controlled substances are valid for one year from the date they were written.
- It must be approved by the Federal Food and Drug Administration (FDA).
- It must be dispensed by a Pharmacy.
- It must be covered under the Plan.

Prescription Drugs covered by the Plan are classified as either generic or brand-name drugs. Brand-name drugs are then considered either preferred brand-name or non-preferred brand-name.

When You need to file a claim

Under most circumstances, You shouldn't need to file a manual claim. Typically, Prescription Drug claims are processed automatically at the Pharmacy or by Express Scripts home delivery. However, if You do not have Your Identification Card with You and You need to obtain a Prescription Drug from a participating In-Network retail Pharmacy, or if you are filling a prescription at an Out-of-Network Pharmacy, You may be required to pay the full cost of the prescription. Then, You may submit a claim along with original receipts directly to Express Scripts for reimbursement of the covered expenses within 12 months. If You file the manual claim within 120 days from the date You filled the Prescription Drug, You will be reimbursed the price you paid (the billed rate) minus the applicable Member Copay. After 120 days, You will be reimbursed at the contracted rate minus the applicable Member Copay.

- Billed rate means the total amount the pharmacy billed for the Prescription Drug
- Contracted rate means the amount the Plan would have paid if You filled the Prescription Drug at an In-Network Retail Pharmacy. The contracted rate could be lower than the amount the Pharmacy billed You.

To obtain a claim form, call the Express Scripts' Member Services number on Your Identification Card or login to Your personal account on express-scripts.com. You also have the option to submit the claim electronically through Your online account.

Limitations

DRUG QUANTITY MANAGEMENT

When You're prescribed certain medicines that are a part of a drug quantity management (DQM) program, we make sure You get it in the amount – or quantity – considered safe and effective by the U.S. Food & Drug Administration (FDA).

How drug quantity management works

The FDA, medical researchers and medicine manufacturers look at individual medicines to determine a recommended maximum quantity considered safe. This is especially important for medicines that are challenging

to take in the proper dose such as inhalers or nose sprays. These medicines are then added to a DQM program. Your Plan decides which of these medicines are covered.

My Prescription Drug is in a DQM program. Do I need to do anything differently?
No. When You submit a prescription for a medicine in a DQM program, You'll get the recommended amount, which should last until it's time for a refill. Note: Sometimes, doctors may write a prescription for a quantity larger than Your Plan covers. In this case, Your pharmacist can contact Your doctor and discuss changing Your prescription to a higher strength, if one is available. If You run out of medicine before Your refill date, it could mean You're using too much and You should talk to Your doctor.

PRIOR AUTHORIZATION

When You're prescribed certain medicines, Your pharmacist may tell You it requires Prior Authorization. That means Express Scripts needs more information to make sure the prescribed medicine will work well for You and Your condition and that it's covered by Your Pharmacy benefit. Only Your physician can provide this information and request a Prior Authorization for this medicine.

How Prior Authorization works
Express Scripts pharmacists regularly review the most current research on newly approved medicines and existing medicines and consult with independent licensed doctors and pharmacists to determine which medicines have been proven to be effective. The Prior Authorization program includes medicines with a variety of different uses. Your Plan determines which medicines are covered.

The first time You try to fill a prescription that needs Prior Authorization (at a retail Pharmacy or the Express Scripts Pharmacy), Your pharmacist should explain that more information is needed from Your doctor to determine whether the medicine is covered by Your Plan. The pharmacist will ask Your doctor to call the Express Scripts Prior Authorization department to find out if the medicine is covered. Prior authorization phone lines are open 24/7 – so a determination can be made right away.

What are my options if my doctor isn't available or Prior Authorization is denied?

- Here's the first option: If the pharmacist can't reach Your doctor, and You need Your Prescription Drug right away, You can ask Your pharmacist about filling a small supply of Your Prescription Drug until Your doctor can be consulted. You may have to pay full price for this small supply.
- Here's the second option: If Your plan doesn't cover the medicine that was originally prescribed, ask Your doctor about getting another prescription for a medicine that is covered. You'll get that medicine for Your plan's Copayment or coinsurance.
- Here's the third option: You can fill the original prescription at full price.

STEP THERAPY

Step therapy simply means making sure You get safe and proven-effective medicine for Your condition at the lowest possible cost to You and Your Plan Sponsor. In other words, it's how You can avoid paying more for the medicine You need.

Here's how step therapy works
A panel of independent licensed physicians, pharmacists and other medical experts work with Express Scripts to recommend medicines for the step therapy program. Together, they review the most current research on thousands of prescription medicines tested and approved by the Food and Drug Administration (FDA). Then they determine the most appropriate medicines to include in the program. Medicines are then grouped in categories, or "steps."

- First-line medicines – These are the first step and are typically generic and lower-cost brand-name medicines. They are proven to be safe and effective, as well as affordable. In most cases, they provide the same health benefit as more expensive medicines, but at a lower cost.
- Second-line medicines – These are the second and third steps and are typically brand-name medicines. They are best suited for the few patients who don't respond to first-line medicines. They're also the most expensive options.

Here's how to start step therapy
The next time Your doctor writes You a prescription, or if Your current medicine qualifies, ask if a first-line generic medicine is right for You. Often, generic medicines have the same chemical makeup as their brand-name counterparts, and the same effect in the body, so the only real difference is cost.

Plans often cover second-line (more expensive) medicines if:

- You've tried the first-line medicine covered by Your step therapy program, and You and Your doctor feel that the medicine doesn't treat Your condition effectively, OR
- You can't take a first-line medicine (for example, because of an allergy), OR
- Your doctor decides that You need a second-line medicine for medical reasons

How do You find out if a first-line medicine is right for You?
Only Your doctor can make that decision. Log in to Your personal account at express-scripts.com or call Express Scripts at the number on Your member ID card to find out if step therapy applies to the medicine Your doctor prescribed. If it does, You can see a list of first-line alternatives. You can give that list to Your doctor to choose the medicine Your plan covers that best treats Your condition.

What happens if Your doctor gives You a prescription that's not on the first-line list for Your plan?
The first time You try to fill the prescription, whether it's in person or submitted to the Express Scripts Pharmacy to be delivered, Your pharmacist should explain that step therapy requires You to try a first-line medicine before a second-line medicine is covered. Since only Your doctor can change Your current prescription, either You or Your pharmacist need to speak with Your doctor to request a first-line medicine that's covered by Your plan. If You need Your prescription right away, You may ask Your pharmacist to fill a small supply until You can consult Your doctor. NOTE: You might have to pay full price for this small supply.

EXCLUDED MEDICATIONS AND PREFERRED ALTERNATIVES

Certain medications are excluded from coverage under the Plan. In most cases, if You fill a prescription for an excluded medication, You will pay the full price.

Call the Express Scripts' Member Services number on Your Identification Card or login to Your personal account on express-scripts.com and select the Price a Medication tool to find out if Your prescription is excluded from coverage.

Your right to appeal

You must use and exhaust this Plan's administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause You to lose Your right to sue regarding an adverse benefit determination.

COVERAGE REVIEW DESCRIPTION

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

HOW TO REQUEST AN INITIAL COVERAGE REVIEW

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at express-scripts.com/PA.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing. A Benefit Coverage Request Form, used to submit the request, is obtained by calling the Customer Service phone number on the back of your prescription card. Complete the form and mail or fax it to:

Express Scripts
Attn: Benefit Coverage Review Department
PO Box 66587 St Louis, MO 63166-6587
Fax 877 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1 800-753-2851.

HOW A COVERAGE REVIEW IS PROCESSED

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	**Decision timeframe** Decisions are completed as soon as possible from receipt of request but no later than:	**Notification of decision**	
		Approval	**Denial**
Standard pre-service*	15 days (retail) 5 days (home delivery)	Patient: Automated call (letter if call not successful) Prescriber: Electronic of fax (letter if fax not successful)	Patient: Letter Prescriber: Electronic or fax (letter if fax not successful)
Standard post-service*	30 days		
Urgent	72 hours**	Automated call and letter	Live call and letter

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.
**Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

HOW TO REQUEST A LEVEL 1 APPEAL OR URGENT APPEAL AFTER AN INITIAL COVERAGE REVIEW HAS BEEN DENIED

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests
Express Scripts
Attn: Clinical Appeals Department
PO Box 66588,
St Louis, MO 63166-6588
Fax 1 877- 852-4070

Administrative appeal requests
Express Scripts
Attn: Administrative Appeals Department
PO Box 66587 St Louis, MO 63166-6587
Fax 1 877- 328-9660

If the patient’s situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient’s provider, the patient’s health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient’s situation is urgent, the expedited review must be requested by phone or fax:

Urgent clinical appeal requests
Phone: 800-753-2851
Fax: 877-852-4070

Urgent administrative appeal requests
Phone: 800-946-3979
Fax: 877-328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 appeal or urgent appeal is processed
Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a Pharmacist, Physician, or trained prior authorization staff member.

Appeal decisions and notifications are made as follows:

<table>
<tr><th rowspan="2">Type of claim</th><th rowspan="2">Decision timeframe:
Decisions are completed as soon as possible from receipt of request but no later than:</th><th colspan="2">Notification of decision</th></tr>
<tr><th>Approval</th><th>Denial</th></tr>
<tr><td>Standard pre-service</td><td>15 days</td><td rowspan="2">Patient: Automated call (letter if call not successful)

Prescriber: Electronic or fax (letter if fax not successful)</td><td rowspan="2">Patient: Letter

Prescriber: Electronic or fax (letter if fax not successful)</td></tr>
<tr><td>Standard post-service</td><td>30 days</td></tr>
<tr><td>Urgent*</td><td>72 hours</td><td>Patient: Automated call and letter

Prescriber: Electronic or fax (letter if fax not successful)</td><td>Patient: Live call and letter

Prescriber: Electronic or fax (letter if fax not successful)</td></tr>
</table>

* If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

HOW TO REQUEST A LEVEL 2 APPEAL AFTER A LEVEL 1 APPEAL IS DENIED

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests
Express Scripts
Attn: Clinical Appeals Department
PO Box 66588, St Louis, MO 63166-6588
Fax 1 877- 852-4070

Administrative appeal requests
Express Scripts
Attn: Administrative Appeals Department
PO Box 66587, St Louis, MO 63166-6587
Fax 1 877-328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Urgent clinical appeal requests
Phone: 800-753-2851
Fax: 877-852-4070

Urgent administrative appeal requests
Phone: 800-946-3979
Fax: 877-328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 appeal is processed
Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a Pharmacist or Physician.

Appeal decisions and notifications are made as follows:

<table>
<tr><th rowspan="2">Type of claim</th><th rowspan="2">Decision timeframe:
Decisions are completed as soon as possible from receipt of request but no later than:</th><th colspan="2">Notification of decision</th></tr>
<tr><th>Approval</th><th>Denial</th></tr>
<tr><td>Standard pre-service</td><td>15 days</td><td rowspan="2">Patient: Automated call (letter if call not successful)

Prescriber: Electronic or fax (letter if fax not successful)</td><td rowspan="2">Patient: Letter

Prescriber: Electronic or fax (letter if fax not successful)</td></tr>
<tr><td>Standard post-service</td><td>30 days</td></tr>
<tr><td>Urgent*</td><td>72 hours</td><td>Patient: Automated call and letter

Prescriber: Electronic or fax (letter if fax not successful)</td><td>Patient: Live call and letter

Prescriber: Electronic or fax (letter if fax not successful)</td></tr>
</table>

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

WHEN AND HOW TO REQUEST AN EXTERNAL REVIEW

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim. The request must be received within 4 months of the date of the final Internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

To submit an external review, the request must be mailed or faxed to Express Scripts.

Express Scripts
Attn: External Appeals Department
PO Box 66588
St. Louis, MO 63166-6588
Phone: 800-753-2851
Fax: 877-852-4070

HOW AN EXTERNAL REVIEW IS PROCESSED

Standard external review

Express Scripts will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant’s right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the plan and Express Scripts

written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent external review
Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

PLAN ADMINISTRATOR APPEAL

If You are dissatisfied with the Claims Administrator's appeal decisions, a voluntary appeal to the Plan Administrator may be available. If You would like to initiate an appeal to the Plan Administrator, please write to the address listed below. Voluntary appeals must be submitted within 60 calendar days from the denial of the last appeal through the Claims Administrator. You are not required to complete a voluntary third level appeal prior to submitting a request for an independent external review.

Plan Administrator
Sentry Insurance Company
Attn: Chief Human Resources Officer
1800 North Point Drive
Stevens Point, WI 54481
Phone: 715-346-6550

You must exhaust the appeal options available through the Claims Administrator prior to submitting an appeal to the Plan Administrator.