

HEALTH BENEFIT BOOKLET

**COUNTY EMPLOYEE BENEFITS
CONSORTIUM OF OHIO (CEBCO)**



BLUE ACCESS (PPO)
Logan County – Plan 4a
Product ACPO9527

Administered by
Community Insurance Company
1351 Wm. Howard Taft Road
Cincinnati, Ohio 45206

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by CEBCO who is responsible for their payment. Community Insurance Company dba Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Benefit Booklet

This Benefit Booklet has been prepared by the Administrator, on behalf of CEBCO, to help explain your health benefits. This document replaces and supersedes any Benefit Booklet or summary that you have received previously. Please read this Benefit Booklet carefully, and refer to it whenever you require medical services.

This Benefit Booklet describes how to get medical care, what health services are covered and not covered, and what portion of the health care costs you will be required to pay. Many of the provisions in this Benefit Booklet are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. You are responsible for knowing the terms of this Benefit Booklet.

This Health Benefit Booklet overrides and replaces any Health Benefit Booklet previously issued to you. The coverage described in this Benefit Booklet is based upon the conditions of the Administrative Services Agreement issued to your Employer, and is based upon the benefit plan that your Employer chose for you. The Administrative Services Agreement, this Benefit Booklet and any endorsements, amendments or riders attached, form the Administrative Services Agreement under which Covered Services are available under your health care benefits.

Many words used in this Benefit Booklet have special meanings. These words are capitalized. If the word or phrase was not explained in the text where it appears, it may be defined in the "Definitions" section. Refer to these definitions for the best understanding of what is being stated.

If you have any questions about this Benefit Booklet, please call the member service number located on the back of your Identification (ID) Card or visit www.anthem.com.

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Federal Patient Protection and Affordable Care Act Notices

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 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 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 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 Administrator's website, www.anthem.com.

Member Rights and Responsibilities

The Plan is committed to:

- Recognizing and respecting you as a Member.
- Encouraging your open discussions with your health care professionals and Providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and the Plan's Network Providers.
- Sharing the Plan's expectations of you as a Member.

You have the right to:

- Participate with your health care professionals and Providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and Providers, and your rights and responsibilities.
- Candidly discuss with your Physicians and Providers appropriate or Medically Necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's Members' rights and responsibilities policies.
- Voice complaints or appeals about: the Administrator's organization, any benefit or coverage decisions the Plan (or the Plan's designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your Physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.

You have the responsibility to:

- Choose a participating Primary Care Physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and Providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that the Administrator and/or your health care professionals and Providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and Provider.
- Tell your health care professional and Provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let CEBCO know if you have any changes to your name, address, or family members covered under your policy.
- Provide the Administrator and CEBCO with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with the Plan.

Schedule of Benefits

The Schedule of Benefits is a summary of the Deductibles, Copayments & Coinsurance and other limits when you receive Covered Services from a Provider. Please refer to the Covered Services section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Benefit Booklet including any attachments or riders. **This Schedule of Benefits lists the Member's responsibility for Covered Services.**

This Schedule of Benefits lists the Member's responsibility for Covered Services.

To receive maximum benefits all Covered Services must be obtained from Network Providers. Benefits for Covered Services are based on the Maximum Allowable Amount. When you utilize a Non-Network Provider you are responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges.

Copayments/Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

Essential Health Benefits provided within this Plan are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

BENEFIT PERIOD

Calendar Year

PRE-EXISTING PERIOD

Services, supplies or other care incurred for any Pre-Existing Conditions in existence 6 months prior to your Enrollment Date are not covered for 12 months after your enrollment date. Pre-Existing exclusions or limitations do not apply to Member's under the age of 19.

Note: The Pre-Existing limitation is waived if you enrolled for coverage during the initial enrollment of your county with CEBCO.

DEPENDENT AGE LIMIT

To the end of the month in which the child attains age 26.

Deductible	Network	Non-Network
Per Member	\$500	\$1,000
Per Family	\$1,000	\$2,000

Note: The Deductible applies to all Covered Services with a Coinsurance amount you incur in a Benefit Period. Copayments are not subject to and do not apply to the Deductible.

Out-of-Pocket Limit	Network	Non-Network
Per Member	\$2,000	\$4,000
Per Family	\$4,000	\$8,000

Note: The Out-of-Pocket Limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period except for the following services:

- Non-Network Human Organ and Tissue Transplant Services

Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period except for the services listed above.

Network and Non-Network Deductibles, Coinsurance, Copayments, and Out-of-Pocket Limits are separate and do not accumulate toward each other.

COVERED SERVICES	COPAYMENTS/COINSURANCE/MAXIMUMS	
	Network	Non-Network
Ambulance Services	30% Coinsurance	30% Coinsurance
Behavioral Health & Substance Abuse Services		
• Inpatient Facility Services	30% Coinsurance	50% Coinsurance
• Inpatient Professional Services	30% Coinsurance	50% Coinsurance
• Outpatient Facility Services (Includes Outpatient Hospital / Alternative Care Facility)	30% Coinsurance	50% Coinsurance
• Outpatient Professional Services	30% Coinsurance	50% Coinsurance
• Other Outpatient Services	30% Coinsurance	50% Coinsurance
• Office Visits	\$25 Copayment per visit	50% Coinsurance

Note: Coverage for the treatment of Behavioral Health and Substance Abuse conditions is provided in compliance with federal law.

Diagnostic Services When rendered as Physician Home Visits and Office Services or Outpatient Services the Copayment/Coinsurance is based on the setting where Covered Services are received except as listed below. Other Diagnostic Services and or tests, including services received at an independent Network lab, may not require a Copayment/Coinsurance.

Laboratory services provided by a facility participating in the Administrator's Laboratory Network (as shown in the provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient Hospital laboratory which is not part of the Administrator's Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.

Note: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services are subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Emergency Room Services	\$150 Copayment per visit	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
Copayment/Coinsurance is waived if you are admitted		

Home Care Services	20% Coinsurance	40% Coinsurance
Maximum Visits per Benefit Period	90 visits, Network and Non-Network combined	

NOTE: Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.

Private Duty Nursing	
Maximum per Member per Benefit Period	\$50,000
Lifetime Maximum	\$100,000

Hospice Services	30% Coinsurance	30% Coinsurance
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Inpatient and Outpatient Professional Services	30% Coinsurance	50% Coinsurance
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Inpatient Facility Services	30% Coinsurance	50% Coinsurance
Maximum days per Benefit Period for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	60 days, combined Network and Non-Network	
Maximum days per Benefit Period for Skilled Nursing Facility	90 days, combined Network and Non-Network	

Colonoscopies and Mammograms (Outpatient)

- **Diagnostic and routine mammograms** No Copayment / Coinsurance up to the Maximum Allowable Amount 50% Coinsurance
 - **Diagnostic and Routine colonoscopies** No Copayment / Coinsurance up to the Maximum Allowable Amount 50% Coinsurance
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Maternity Services Copayments/Coinsurance based on setting where Covered Services are received 50% Coinsurance

Medical Supplies, Durable Medical Equipment and Appliances 30% Coinsurance 50% Coinsurance

(Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.)

NOTE: If durable medical equipment or appliances are obtained through your PCP/SCP or another Network Physician's office, Urgent Care Center Services, Other Outpatient Services, Home Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where Covered Services are received.

Outpatient Services

Outpatient Surgery Hospital/Alternative Care Facility 30% Coinsurance 50% Coinsurance

Other Outpatient Services 30% Coinsurance 50% Coinsurance

Note: Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Physician Home Visits and Office Services

Primary Care Physician (PCP) \$25 Copayment per visit 50% Coinsurance

Specialty Care Physician (SCP) \$35 Copayment per visit 50% Coinsurance

Allergy injections \$5 Copayment per visit 50% Coinsurance

NOTES: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received in a Physician's office are subject to the Other Outpatient Services Copayment/Coinsurance.

The allergy injection Copayment/Coinsurance will be applied when the injection(s) is billed by itself. The office visit Copayment/Coinsurance will apply if an office visit is billed with an allergy injection.

Preventive Care Services	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	50% Coinsurance
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Therapy Services	Copayments/Coinsurance based on setting where Covered Services are received	50% Coinsurance
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NOTE: If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.

Maximum Visits per Benefit Period for:

Physical Therapy	30 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.	
Occupational Therapy	30 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.	
Speech Therapy	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.	
Manipulation Therapy	12 visits, combined Network and Non-Network	

Urgent Care Center Services	\$50 Copayment per visit	\$50 Copayment per visit
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Human Organ and Tissue Transplant Services

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- Cornea and kidney transplants; and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to applicable Member cost shares.

Transplant Benefit Period	Network Transplant Provider	Non-Network Transplant Provider
Deductible	Network Transplant Provider	Non-Network Transplant Provider
Covered Transplant Procedure during the Transplant Benefit Period	Network Transplant Provider	Non-Network Transplant Provider

Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 -50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility.

The later of 30 days or date of discharge following a Covered Transplant Procedure at a Non Network Transplant Provider Facility.

Not applicable

Applicable. During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.

No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.

During the Transplant Benefit Period, You will pay 50% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit.

If the Provider is also a Network Provider for the Plan (for services other than Transplant Services and Procedures), then you will **not** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount.

If the Provider is a Non-Network Provider for the Plan, you **will** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.

Covered Transplant Procedure during the Transplant Benefit Period	Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount.	You are responsible for 50% of Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	Covered, as approved by the Plan, up to a \$10,000 benefit limit per transplant	Not Covered for Transplants received at a Non-Network Transplant Provider Facility
Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as approved by the Plan, up to a \$30,000 benefit limit	Covered, as approved by the Plan, up to a \$30,000 benefit limit. You will be responsible for 50% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.
Live Donor Health Services	Covered as determined by the Plan	Covered as determined by the Plan. These charges will NOT apply to your Out-of-Pocket Limit

Covered Services

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **To receive maximum benefits for Covered Services, care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider to be a Covered Service, except for Emergency Care and Urgent Care. Services which are not received from a PCP, SCP or another Network Provider or approved as an Authorized Service will be considered a Non-Network service, except as specified above.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care and Urgent Care.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. The Plan cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Plan, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization/Precertification has been obtained. The Administrator bases its' decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Administrator's clinical coverage guidelines and medical policy. The Administrator may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Benefit Booklet. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. The Plan's payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, or Benefit Period Limit/Maximum in this Benefit Booklet.**

Ambulance Services

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

Other vehicles which do not meet this definition, including but not limited to ambulettes, are not Covered Services.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by the Plan to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

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

Behavioral Health Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for Inpatient Services, Outpatient Services, and Physician Home Visits & Office Services for the treatment of Behavioral Health conditions is provided in compliance with federal law.

Behavioral Health Services also includes coverage for Biologically Based Mental Illness services. Biologically Based Mental Illness means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Cancer Clinical Trials

Benefits are available for services for routine patient care rendered as part of a cancer clinical trial if the services are otherwise Covered Services under this Plan and the clinical trial meets all of the following criteria:

- The purpose of the trial is to test whether the intervention potentially improves the trial participant's health or the treatment is given with the intention of improving the trial participants health, and is not designed simply to test toxicity or disease pathophysiology;
- The trial does one of the following:
 1. Tests how to administer a health care service, item, or drug for the treatment of cancer;
 2. Tests responses to a health care service, item, or drug for the treatment of cancer;
 3. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer; or
 4. Studies new uses of health care services, items, or drugs for the treatment of cancer;
- The trial is approved by one of the following:
 1. The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
 2. The United States Food and Drug Administration;
 3. The United States Department of Defense; or
 4. The United States Department of Veteran's Affairs.

Benefits do not, however, include the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

Dental Services

Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are 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 patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

Other Dental Services

The only other dental expenses that are Covered Services are facility charges for Outpatient Services. Benefits are payable for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Diagnostic Services

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).

- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocardiograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic services other than those approved to be received in a Physician's office, you may be required to use the Administrator's independent laboratory Network Provider called the Reference Laboratory Network (RLN).

When Diagnostic radiology is performed in a Network Physician's Office, no Copayment is required. Any Coinsurance from a Network or a Non-Network Physician will still apply.

Emergency Care and Urgent Care Services

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which the Administrator determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider.

Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. A Non-Network Provider of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is called "balance billing").

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method the Administrator generally uses to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment/Coinsurance for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Administrator, on behalf of CEBCO, or verify that your Physician has notified the Administrator of your admission within 24 hours or as soon as possible within a reasonable period of time. When the Administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Administrator, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with the Administrator or is a BlueCard Provider, you will be financially responsible for any care the Administrator, on behalf of CEBCO, determines is not Medically Necessary.

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as a Non-Network service unless the Administrator authorizes the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Covered Services rendered by a Non-Network Urgent Care Center will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your Schedule of Benefits for benefit limitations.

Home Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional Guidance.
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by the Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.

- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from the Administrator's Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months.

When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide.

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Inpatient Services

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Administrator, on behalf of CEBCO. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Maternity Services

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of

pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to the Administrator.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copayment.

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Physician-directed follow-up care after delivery is also covered. Services covered as follow-up care include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any Medically Necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. the antepartum, intrapartum, and postpartum course of the mother and infant;
 2. the gestational stage, birth weight, and clinical condition of the infant;
 3. the demonstrated ability of the mother to care for the infant after discharge; and
 4. the availability of postdischarge follow-up to verify the condition of the infant after discharge.
- **Covered Services include at-home post delivery care visits** at your residence by a Physician or Nurse performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:
 1. parent education;
 2. assistance and training in breast or bottle feeding; and
 3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office or a Specialty Care Provider's facility.

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by the Administrator, on behalf of CEBCO. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).
- In addition, replacement of purchased equipment, supplies or appliance may be covered if:
 1. The equipment, supply or appliance is worn out or no longer functions.
 2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
 3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
 4. The equipment, supply or appliance is damaged and cannot be repaired.

The Administrator, on behalf of CEBCO may establish reasonable quantity limits for certain supplies, equipment or appliance described below. A detailed listing of supplies, equipment or appliances that are not covered by the Plan including quantity limits, is available to you upon request. Please call the customer service number on your Identification Card or visit the Administrator's website at www.anthem.com. This list is subject to change.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** – Certain supplies and equipment for the management of disease that the Administrator approves are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Plan's Prescription Drug benefit or if the supplies, equipment or appliances are not received from the Plan's Mail Service or from a Network/Participating Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Prescription Drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depo-Provera. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1. Allergy serum extracts
2. Chem strips, Glucometer, Lancets
3. Clinitest
4. Elastic stockings or supports. These items must be purchased by prescription or through a Hospital. They must be Medically Necessary for the treatment of an injury or condition requiring stockings. The Plan may establish reasonable limits on the number of pairs allowed per Member per Benefit Period.

5. Needles/syringes
6. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators
2. Arch supports
3. Doughnut cushions
4. Hot packs, ice bags
5. vitamins
6. medinjectors

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

Durable medical equipment - The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors
8. Augmentive communication devices are covered when the Administrator approves based on the Member's condition.

Non-covered items may include but are not limited to:

1. Air conditioners
2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

Outpatient Services

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by the Administrator, on behalf of CEBCO. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care", and "Home Care Services", for services covered by the Plan. For Emergency Care refer to the "Emergency Care and Urgent Care" section.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Preventive Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, or Copayments.

Preventive Care services include, Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Plan with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider. That means the Plan pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force.
Examples of these services are screenings for:
 - 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; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

You may call Customer Service using the number on your ID card for additional information about these services. (or view the federal government’s web sites, <http://www.healthcare.gov/center/regulations/prevention.html>; or <http://www.ahrq.gov/clinic/uspstfix.htm>; <http://www.cdc.gov/vaccines/recs/acip/>.)

Covered Services also include the following services required by state and federal law:

- Routine screening mammograms. The total benefit for a screening mammography under this Plan, regardless of the number of claims submitted by Providers, will not exceed one hundred thirty per cent (130%) of the Medicare reimbursement rate in the state of Ohio for a screening mammography. If a Provider, Hospital, or other health care facility provides a service that is a component of the screening mammography and submits a separate claim for that component, a separate payment shall be made to the Provider, Hospital, or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for mammography constitutes full payment under this Certificate. No Provider, Hospital, or other health care facility

shall seek or receive compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio.

- Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test).
- Child health supervision services from the moment of birth until age nine. Child health supervision services mean periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with Ohio law. Periodic review means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Other Covered Services are:

- Routine hearing screenings
- Routine vision screenings

Surgical Services

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as approved by the Administrator, on behalf of CEBCO.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact the Administrator, on behalf of CEBCO for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Mastectomy Notice

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Sterilization

Sterilization is a Covered Service.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

They are covered if provided within the Plan's guidelines.

Therapy Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Human Organ and Tissue Transplant Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine**

your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ and tissue transplants or transfusions as determined by the Administrator, on behalf of CEBCO including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 -50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility or the later of 30 days or date of discharge following a Covered Transplant Procedure at a Non Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize your benefits, the 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 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 Customer Service telephone number on the back of your Identification Card **and ask for the transplant coordinator**. Even if the Administrator issues a prior approval for the Covered Transplant Procedure, you or your Provider must call the Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest 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 harvest 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 harvest 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 Administrator, on behalf of CEBCO 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 patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator for detailed information.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Non-Covered Services/Exclusions

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide benefits for procedures, equipment, services, supplies or charges:

1. Which the Administrator, on behalf of CEBCO, determines are not Medically Necessary or do not meet the Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet, or recognized by the Plan.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator, on behalf of CEBCO.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
9. For court ordered testing or care unless Medically Necessary.
10. For which you have no legal obligation to pay in the absence of this or like coverage.
11. For any Pre-Existing Condition for the time period specified in the Schedule of Benefits, subject to the Portability provision of this Benefit Booklet. This Exclusion is not applicable to Member's under the age of 19.
12. For 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.
13. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
14. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

15. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
16. For missed or canceled appointments.
17. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by the Administrator, on behalf of CEBCO, or specifically stated as a Covered Service.
18. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if a Member had applied for Parts A and/or B, except, as specified elsewhere in this Benefit Booklet or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.
19. Charges in excess of the Plan's Maximum Allowable Amounts.
20. Incurred prior to your Effective Date.
21. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
22. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by the Administrator, on behalf of CEBCO, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
23. Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
24. For Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional.
25. For Residential Treatment services. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a Physician weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
26. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
 - cleaning and soaking the feet.
 - applying skin creams in order to maintain skin tone.
 - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
27. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
28. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Benefit Booklet. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

- extraction, restoration and replacement of teeth.
 - medical or surgical treatments of dental conditions.
 - services to improve dental clinical outcomes.
29. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
30. For Dental implants.
31. For Dental braces.
32. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
- transplant preparation.
 - initiation of immunosuppressives.
 - direct treatment of acute traumatic injury, cancer or cleft palate.
33. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
34. Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in the "Covered Services" section. Weight loss programs for medical reasons are also excluded.
35. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by the Administrator, on behalf of CEBCO, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self funded plan prior to coverage under this Plan. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.
36. For marital counseling.
37. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
38. For vision orthoptic training.
39. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Benefit Booklet.
40. For hearing aids or examinations for prescribing or fitting them.
41. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
42. For reversal of sterilization.

43. For diagnostic testing or treatment related to infertility.
44. For personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.
45. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Administrator, on behalf of CEBCO.
46. For care received in an emergency room which is not Emergency Care, except as specified in this Benefit Booklet. This includes, but is not limited to suture removal in an emergency room.
47. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
48. For expenses incurred at a health spa or similar facility.
49. For self-help training and other forms of non-medical self care, except as otherwise provided herein.
50. For examinations relating to research screenings.
51. For stand-by charges of a Physician.
52. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
53. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy.
54. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
55. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
56. For Manipulation Therapy services rendered in the home as part of Home Care Services.
57. Any new FDA Approved Drug Product or Technology (**including but not limited to medications, medical supplies, or devices**) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
58. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. Prescription drugs for sexual or erectile dysfunction will be covered.
59. For Outpatient Prescription Legend Drugs or Mail Order Drugs.

60. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergal synchronization technique (BEST) and iridology-study of the iris.
61. For hiring, or the services of, a surrogate mother.
62. For surgical treatment of gynecomastia.
63. For treatment of hyperhidrosis (excessive sweating).
64. For any service for which you are responsible under the terms of this Benefit Booklet to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.
65. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Administrator, on behalf of CEBCO, through Prior Authorization.
66. Complications directly related to a service or treatment that is a non Covered Service under the Plan because it was determined by the Administrator, on behalf of CEBCO, to be Experimental/Investigational or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
67. For 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.
68. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
69. Treatment of telangiectatic dermal veins (spider veins) by any method.
70. Reconstructive services except as specifically stated in the **Covered Services** section of this Benefit Booklet, or as required by law.
71. For nutritional and dietary supplements, except as provided in the Covered Services section of this Benefit Booklet or as required by law. This exclusion includes, but is not limited to, those supplements that by law do not require either the written prescription of a Physician or dispensing by a licensed pharmacist. It also includes vitamins and food replacements, such as infant formulas and enteral formulas.
72. For room and board charges unless the treatment provided meets the Administrator's Medical Necessity criteria for Inpatient admission for your condition.
73. For supervised living or halfway houses.
74. For services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
75. For elective abortions accomplished by any means.

Experimental/Investigative Services Exclusion

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Administrator, on behalf of CEBCO, determines in its sole discretion to be Experimental/Investigative is not covered under the Plan.

The Administrator, on behalf of CEBCO, will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Administrator, on behalf of CEBCO, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

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

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Administrator, on behalf of CEBCO. In determining whether a Service is Experimental/Investigative, the Administrator, on behalf of CEBCO, 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 Administrator, on behalf of CEBCO 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 Administrator, on behalf of CEBCO, 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.

Eligibility and Enrollment

Benefits payable under the Plan are available to you because of your employment with or membership with or retirement from CEBCO.

In order for you to participate in the Plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods, and Actively At Work standards. The specific time periods and other standards for participation in the Plan are determined by CEBCO, or state and/or federal law. Eligibility requirements are described in general terms below.

For more specific eligibility information, you should see your Human Resources or Benefits department.

Eligibility

Unless CEBCO notifies you otherwise, the following eligibility rules apply:

Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be an employee of a CEBCO member county or entity who is entitled to participate in the benefit plan arranged by CEBCO, who has satisfied any probationary or waiting period established by CEBCO who is Actively At Work, and meets the Plan's eligibility criteria.

Dependents

To be eligible to enroll under the Plan as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by CEBCO and be:

- The Subscriber's legal spouse.
- The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children. The event date for an adopted child is the earlier of the date of adoption or date of placement for adoption. Placement for adoption means the assumption and retention of legal obligation for total and partial support for a child in anticipation of adoption of such child (included are natural children, adopted children and children who CEBCO has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law).
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law

All enrolled eligible, children may continue to be covered until the age limit listed in the Schedule of Benefits. At the Subscriber's request, eligibility will be continued past the age limit until the end of the month in which the Dependent child reaches age 28 if the child:

- Is the natural child, stepchild or adopted child of the Subscriber.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period they would become ineligible for benefits. The Plan must certify the Dependent's eligibility. CEBCO must be informed of the Dependent's eligibility for continuation of benefits under the Plan within 31 days after the Dependent would normally become ineligible. You must notify the Plan if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

CEBCO may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's benefits under the Plan.

To enroll children under the Plan, the Subscriber may be required to complete and provide a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under the Plan. Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for benefits under the Plan unless required by the laws of this state.

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 parent's termination of employment or 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.

Out of Service Area Dependent Child Coverage

Benefits for Covered Services will be provided for enrolled Dependent children who reside outside of the Service Area due to such children attending an out of Service Area educational institution or residing with the Subscriber's former spouse. Payment of benefits for these additional Covered Services is limited to the Maximum Allowable Amount. Payment is subject to any Copayment or Coinsurance. You may be responsible for any amount in excess of the Maximum Allowable Amount.

Enrollment

Persons who are eligible to enroll as Members must enroll at the time agreed upon by CEBCO. Otherwise, they may be subject to the terms of Late Enrollment or Special Enrollment as set forth in this Benefit Booklet.

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage through CEBCO. That enrollment must be received by the date established by CEBCO, and agreed to by the Administrator, for Initial Enrollment. If the Administrator does not receive the Initial Enrollment by this date, the Eligible Person can only enroll for benefits during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

If a dependent of the Eligible Person qualifies as a Dependent under the Plan at the time of the Eligible Person's Initial Enrollment, but does not enroll, that person can only enroll for benefits during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on Eligible Dependents.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for illness or injury for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days only if the Subscriber submits through CEBCO, a change to add the child under the Subscriber's Plan. The change must be submitted within 31 days after the birth of the child. Failure to notify the Plan during this 31 day period will result in no benefits for the newborn and the newborn can only enroll for benefits during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

A child will be considered adopted from the earlier of (1) the moment of placement in your home or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child

is removed from your home prior to issuance of a legal decree of adoption. Pre-Existing exclusions or limitations do not apply to Member's under the age of 19.

Adding a Child due to Legal Guardianship

If a subscriber or the Subscriber's spouse becomes the legal guardian for a child, an application must be submitted within 31 days of the date legal guardianship is approved by the court or the child will be treated as a Late Enrollee. Coverage will be effective on the date the court approves legal guardianship if CEBCO receives an application within 31 days of that qualifying event.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under this Benefit Booklet, the Plan will permit your child to enroll at any time without regard to any open enrollment limits and will provide the benefits of this Benefit Booklet in accordance with the order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Benefit Booklet will be paid, at our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Plan will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Plan directly.

Special Enrollment/Special Enrollees

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, provided that you request enrollment within 31 days after your other coverage ends. 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 in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If the Administrator receives an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee.

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) under Medicaid or CHIP.

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If the Plan receives an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, the Plan will not be able to enroll that person until the Employer's next Open Enrollment.

Application forms are available from CEBCO.

Portability

Any Pre-Existing Condition waiting period will be reduced by the aggregate of the periods of prior creditable coverage applicable to you as of your Enrollment Date under this Plan. Creditable coverage is prior coverage you had from: a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan. You have the opportunity to prove that you have prior creditable coverage and the Administrator and/or the Employer will assist you in obtaining that information if required. Pre-Existing exclusions or limitations do not apply to Member's under the age of 19.

Late Enrollment

An Eligible Person or Dependent who did not request enrollment for coverage with the Plan during the initial enrollment period, as a newly eligible person, or a Special Enrollment period during which the individual was entitled to enroll is considered a Late Enrollee and not eligible to enroll for coverage with the Plan until the next open enrollment period.

Notice of Changes

The Subscriber is responsible for notifying CEBCO of any changes which will affect his or her eligibility or that of Dependents for services or benefits under the Plan. CEBCO must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare. Failure to notify CEBCO of persons no longer eligible for services will not obligate the Plan to pay for such services. Acceptance of payments from CEBCO for persons no longer eligible for services will not obligate the Plan to pay for such services.

All notifications by CEBCO must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to single Coverage. CEBCO must be notified when a Member becomes eligible for Medicare.

If CEBCO determines that the Member is not eligible for benefits, CEBCO may cancel that Member's coverage immediately. The termination date shall be retroactive to the date the person was no longer eligible. CEBCO has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's benefits.

Nondiscrimination

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

Effective Date of Coverage

For more specific information concerning your Effective Date, you should see your Human Resources or benefits department.

Continuous Coverage

If CEBCO moves from one Anthem Blue Cross Blue Shield plan to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately prior to enrolling in this product with no break in coverage, then you may receive credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by CEBCO. Any maximums, including the Lifetime Maximum, when applicable, will be carried over and charged against the maximums under this Benefit Booklet.

If CEBCO offers more than one Anthem product, and you change from one Anthem product to another with no break in coverage, you will receive credit for any accrued Deductible and, if applicable, Out of Pocket amounts.

If CEBCO offers coverage through other products or carriers in addition to Anthem's, and you change products or carriers to enroll in this Anthem product with no break in coverage, you will receive credit for any accrued Deductible, Out of Pocket, and any maximums amounts.

THIS SECTION DOES NOT APPLY TO YOU IF YOU:

- change from an individual Anthem Blue Cross Blue Shield policy to a group Anthem Blue Cross Blue Shield plan;
- change employers and both have Anthem Blue Cross Blue Shield coverage; or
- are a new Member of CEBCO who joins CEBCO after CEBCO's initial enrollment with Anthem. Such new Members will receive credit from their prior carrier as described in the Portability section.

Statements and Forms

Subscribers or applicants for coverage shall complete and submit to the Administrator applications, medical review questionnaires, or other forms or statements the Administrator, on behalf of CEBCO, may reasonably request. Subscribers or applicants for coverage represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for coverage understand that all rights to benefits under the Plan are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a Member may result in termination of benefits as provided in the Termination section.

Delivery of Documents

The Administrator, on behalf of CEBCO, will provide an Identification Card for each Member and a Benefit Booklet for each Subscriber.

Termination, Continuation, and Conversion

Termination

It is the responsibility of CEBCO to notify you of the termination of the Plan.

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on CEBCO's agreement with the Plan and your specific circumstances, such as whether fees have been paid in full:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which the Plan received your notice of termination.
- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Benefit Booklet, your coverage generally will terminate on the last day of the billing period. CEBCO and/or you must notify the Plan immediately if you cease to meet the eligibility requirements. CEBCO and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you engage in fraudulent conduct or furnish the Plan fraudulent or misleading material information relating to claims or application for coverage, then the Plan may terminate your coverage. Termination is generally effective 31 days after the Plan's notice of termination is mailed. You are responsible to pay the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments or Coinsurance made or Premium paid for such services. We will also terminate your Dependent's coverage, generally effective on the date your coverage was terminated. The Plan will notify CEBCO in the event the Plan terminate your and your Dependent's coverage.
- A Dependent's coverage will generally terminate at the end of the billing period in which notice was received by the Plan that the person no longer meets the definition of Dependent.
- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.
- If you elect coverage under another carrier's health benefit plan or under any other non-Anthem plan which is offered by, through, or in connection with CEBCO as an option instead of this Plan, then coverage for you and your Dependents will generally terminate at the end of the billing period for which premium has been paid, subject to the consent of CEBCO. CEBCO agrees to immediately notify the Plan that you have elected coverage elsewhere.
- If you fail to pay or fail to make satisfactory arrangements to pay any amount due to the Plan or Network Providers (including the failure to pay required Deductibles, and/or Copayments or Coinsurance), the Plan may terminate your coverage and may also terminate the coverage of all your Dependents, generally effective immediately upon the Plan's written notice to CEBCO.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon the Plan's written notice to CEBCO. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another Group health Plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. Certifications may be requested within 24 months of losing coverage.

You may also request a certification be provided to you at any other time, even if you have not lost coverage under this Plan. If you have any questions, contact the customer service telephone number listed on the back of your Identification Card.

Federal Continuation of Coverage (COBRA)

Subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, the Plan provides that each of the qualified beneficiaries listed below has the right to choose continuation coverage if his or her coverage under the Benefit Booklet would otherwise end. The election period lasts for 60 days and begins to run on the later of

1. the date that you would lose coverage due to the qualifying event; or
2. the date you are sent notice of your right to continuation coverage.

Unless the election specifies otherwise, an election by a covered Subscriber or a spouse is also considered an election on behalf of any other qualified beneficiary who would also lose coverage due to that qualifying event.

Election Period for Workers who are Receiving Trade Adjustment Assistance

An additional COBRA election period is available for certain eligible workers who have not already elected COBRA. This second election period applies to individuals who have petitions on file requesting certification for trade adjustment assistance under the 1974 Trade Act on or after November 4, 2002.

You are eligible to elect COBRA during this second election period if you:

1. are receiving trade adjustment assistance, as demonstrated by appropriate government certification;
2. lost group health plan coverage due to a job loss that resulted in eligibility for trade adjustment assistance; and
3. failed to elect COBRA during the regular COBRA election period that was triggered by that job loss.

This second 60-day COBRA election period begins on the first day of the month in which you are determined to be eligible for trade adjustment assistance, but no election may be made later than six months after the initial loss of group health plan coverage.

Any COBRA coverage elected through this second election period will begin with the first day of the second election period, and not on the day on which you first lost group coverage. However, the time between the initial loss of coverage and the start of the second election period will not count in determining if there is a 63-day break in coverage for purposes of HIPAA.

Qualifying Events and Qualified Beneficiaries

The following qualified beneficiaries (not including nonresident aliens who received no income constituting earned income under federal law from CEBCO and the nonresident aliens' Dependents) have the right to continuation coverage when one of the following qualifying events results in a loss of coverage under the contract:

1. Upon the death of the covered Subscriber: the spouse and the Dependent children.

2. Upon the covered Subscriber's termination (for other than gross misconduct) or reduction in work hours; the Subscriber and his or her eligible Dependents.
3. Upon divorce or legal separation of the covered Subscriber: the divorced or legally separated spouse and Dependent children.
4. Upon the covered Subscriber becoming enrolled in Medicare under Title XVIII of the Social Security Act: the spouse and Dependent children.
5. Upon the disqualification of a Dependent child under the Benefit Booklet's eligibility requirements: the Dependent child not meeting such requirements.
6. Upon CEBCO's filing of a Title XI Bankruptcy: the retired covered Subscriber and his or her Dependents who (a) as a result of the bankruptcy filing would experience a substantial elimination of health coverage, under the Benefit Booklet, within a year of the bankruptcy filing; or (b) has experienced an elimination of coverage during the year preceding the bankruptcy filing

For the purpose of this section, coverage for a Dependent child includes coverage for any child born to or placed for adoption with a qualified beneficiary after a qualifying event if proper notice is provided to CEBCO of the birth or adoption.

If you have already enrolled in Medicare before the time of your qualifying event, you may still elect COBRA coverage. If you enroll in Medicare after you have already elected COBRA coverage, then your COBRA coverage will terminate as stated below in number 4, Cancellation.

If a Spouse or Dependent Child of a Subscriber is covered through a Subscriber by alternative coverage, and the right to receive the alternative coverage will cease upon the death of or divorce or legal separation from the Subscriber, the end of the alternative coverage shall be considered a qualifying event as described in 1 and 3 above, regardless of whether the alternative coverage would satisfy COBRA continuation coverage rules. "Alternative coverage" means coverage provided by an employer without regard to COBRA continuation coverage, as a result of: state or local law; industry practice; a collective bargaining or severance agreement; plan procedure; or disability or workers compensation leave.

Duration of Continuation Coverage

1. For the events explained in paragraphs "1," "3," "4," and "5" under "Qualifying Events and Qualified Beneficiaries," continuation coverage is provided for 36 months after the date of the initial qualifying event.
2. For the event explained in paragraph "2" under "Qualifying Events and Qualified Beneficiaries," continuation coverage is provided for 18 months after the date of the qualifying event.

Exceptions:

- a. If the qualifying event under paragraphs "1," "3," "4," or "5" above occurs during the 18-month period, continuation coverage will be continued an additional 18 months; or
- b. If a qualified beneficiary is determined under Titles II or XVI of the Social Security Act to be disabled at any time prior to or during the first 60 days of continuation coverage under paragraph "2," under "Qualifying Events and Qualified Beneficiaries," continuation coverage will be extended an additional 11 months.

However, coverage will be extended only if the qualified beneficiary gives notice of the disability within 60 days after the disability is determined and before the end of the original 18-month continuation period. When the qualified beneficiary is no longer disabled, he or she must notify CEBCO within 30 days after the final determination is made under Titles II and XVI.

- c. If the Subscriber became enrolled in Medicare prior to the qualifying event, the period of coverage for qualified beneficiaries other than the Subscriber shall be the longer of 18 months from the termination or reduction in hours of employment or 36 months from the earlier Medicare entitlement.
3. For the event explained in paragraph "6" above, continuation coverage is provided until the death of the retired covered Subscriber. If the covered Subscriber dies before the occurrence of the qualifying event, continuation

coverage is provided until the death of the surviving spouse. Upon the death of the covered Subscriber, his or her Dependents (other than a surviving spouse entitled to lifetime coverage) are entitled to continuation coverage as explained in paragraph "1" of the preceding section.

The maximum period for all qualifying events is 36 months, except as may occur under paragraph "3" immediately above.

Fees

You must pay fees for any period of continuation coverage. If you make the election after the qualifying event, any fees due must be paid by 45 days after the date of the election.

Cancellation

Continuation coverage will terminate if:

1. CEBCO ceases to provide any group health Plan to its Members;
2. fees are not paid on time;
3. upon the date, after the date of continuation coverage election, the qualified beneficiary first becomes covered under another group health plan that:
 - a. does not contain any limitation regarding a pre-existing condition of the beneficiary; or
 - b. does contain a pre-existing exclusion or limitation that would apply to the beneficiary but is not applicable because of the Federal Health Insurance Portability and Accountability Act of 1996's rule on pre-existing condition clauses;
4. upon the date, after the date of continuation coverage election, a qualified beneficiary other than beneficiaries that are provided continuation of coverage under paragraph "6," under "Qualifying Events and Qualified Beneficiaries," first becomes enrolled in Medicare benefits under Title XVIII of the Social Security Act; or
5. a qualified beneficiary who was disabled under paragraph "2" under "Qualifying Events and Qualified Beneficiaries," is no longer disabled. The additional 11 months of extended continuation coverage will be terminated on the first day of the month that begins more than 30 days after the date of the final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled.

Family and Medical Leave Act

Subject to the requirements of the Family and Medical Leave Act (FMLA) as amended, any Subscriber entitled to FMLA leave may continue their benefits, and any Dependents' benefits, under the Plan as if continuously employed during the entire FMLA leave period. Certain limitations stated below may apply. No new conditions or waiting periods will apply to the benefits upon your return to work.

You may be entitled to FMLA leave for the following reasons:

- Birth of a child, and to care for such child;
- Placement of a child with you for adoption or foster care;
- To care for your seriously ill spouse, child, or parent;
- A serious health condition that makes you unable to perform your job functions.

CEBCO is responsible for determination of your eligibility, rights, or length of leave period for FMLA for purposes of continuing your benefits under the Plan.

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1984, as amended.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying CEBCO in advance and payment of any required contribution for health coverage. This may include the amount CEBCO normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under the Plan shall be the lesser of:

- The 24-month period beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under the Plan. No Exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

How to Obtain Covered Services

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Service from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care, Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider, or the Administrator to be sure that Prior Authorization and/or precertification has been obtained.

If a Non-Network Provider meets the Administrator's enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network Provider for the product associated with the Plan.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider benefits will be paid at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of Physicians. The Administrator, on behalf of CEBCO, has final authority to determine the Medical Necessity of the service.

The Administrator, on behalf of CEBCO, may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the **Complaint and Appeals** section of this Benefit Booklet.

- **Network Providers** - include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with the Administrator to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatrician or other Network Providers as allowed by the Plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange your health care services. SCP's are Network Physician who provide specialty medical services not normally provided by a PCP.

For services rendered by Network Providers:

1. You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from the Plan and not from you except for approved Coinsurance, Copayments and/or Deductibles. You may be billed by your Network Provider(s) for any non-Covered Services you receive or when you have not acted in accordance with the Plan.
2. Health Care Management is the responsibility of the Network Provider.

If there is no Network Provider who is qualified to perform the treatment you require, contact the Administrator prior to receiving the service or treatment and the Administrator, on behalf of CEBCO, may approve a Non-Network Provider for that service as an Authorized Service.

Non-Network Services

Services which are not obtained from a PCP, SCP, or another Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exception is Emergency Care and Urgent Care. In addition, certain services are not covered unless obtained from a Network Provider, see your Schedule of Benefits.

For services rendered by a Non-Network Provider, you are responsible for:

- The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Coinsurance/Copayments;

- Services that are not Medically Necessary;
- Non-Covered Services;
- Filing claims; and
- Higher cost sharing amounts.

Relationship of Parties (Administrator - Network Providers)

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

The Administrator shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

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 and Non-Network Providers and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Administrator.

Not Liable For Provider Acts or Omissions

The Administrator and/or CEBCO are not responsible for the actual care you receive from any person. This Benefit Booklet does not give anyone any claim, right, or cause of action against the Plan based on what a Provider does or does not do.

Identification Card

When you receive care from your Network Provider, or other Provider, you must show your Identification Card. Possession of an Identification Card confers no rights to services or other benefits under the Plan. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Fees under the Plan have been paid. Any person receiving services or other benefits to which he or she is not then entitled under the provisions of the Plan will be responsible for the actual cost of such services or benefits.

Health Care Management

Health Care Management includes the processes of Precertification, Predetermination and Medical Review. Its purpose is to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources and optimizing the health of the Members. These processes are described in the following section.

If you have any questions regarding the information contained in this section, you may call the Precertification telephone number on the back of your Identification Card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Physician must notify the Administrator within 24 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. The Administrator will review your Benefit Booklet to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Benefit Booklet or is Experimental/Investigative as that term is defined in this Benefit Booklet.

Medical Review – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which the Administrator has a related clinical coverage guideline and are typically initiated by the Administrator.

Most Network Providers know which services require Precertification and will obtain any required Precertification or request a Predetermination if they feel it is necessary. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. The ordering Provider, facility or attending Physician will contact the Administrator to request a Precertification or Predetermination review (“requesting Provider”). The Administrator will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services provided by a Network Provider	Services provided by a BlueCard/Non-Network/Non-Participating Provider
Provider	<ul style="list-style-type: none"> Member is responsible for Precertification. Member is financially responsible for service and/or setting that are/is not covered under the Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative.

The Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventative care clinical coverage guidelines, to assist in making Medical Necessity decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. The Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Benefit Booklet and the Administrative Services Agreement take precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, contact the Precertification telephone number on the back of your Identification Card.

Request Categories:

Urgent – a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member’s medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.

If an urgent care review request is not approved, the Member may proceed with an expedited external review while simultaneously pursuing an appeal through the Administrator’s Level 1 internal appeal process.

Prospective – a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.

Concurrent - a request for Precertification or Predetermination that is conducted during the course of treatment or admission.

If a concurrent review request is not approved, a Member who is receiving an ongoing course of treatment may proceed with an expedited external review while simultaneously pursuing an appeal through the Administrator’s Level 1 internal appeal process.

Retrospective - a request for Precertification that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, the Administrator will abide by state regulations. You may call the telephone number on the back of your membership card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	24 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	72 hours or 2 business days from the receipt of request whichever is less
Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	24 hours or 1 business day from the receipt of the request whichever is less
Concurrent Non-Urgent	72 hours or 1 business day from the receipt of the request whichever is less
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make the Administrator’s decision, the Administrator will notify the requesting Provider and send written notification to you or your authorized representative of the specific information necessary to complete the review. If the Administrator does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in the Administrator’s possession.

The Administrator will provide notification of its decision in accordance with state and federal regulations. Notification may be given by the following methods:

Verbal: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.

Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the member or authorized member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date you receive service:

1. you must be eligible for benefits;
2. premium must be paid for the time period that services are rendered;
3. the service or surgery must be a covered benefit under the Plan;
4. the service cannot be subject to an exclusion under the Plan, including but not limited to a Pre-Existing Condition limitation or exclusion; and
5. you must not have exceeded any applicable limits under the Plan.

CARE MANAGEMENT

Care Management is a Health Care Management feature designed to help promote the timely coordination of services for Members with health-care related needs due to serious, complex, and/or chronic medical conditions. The Administrator's Care Management programs coordinate health care benefits and available services to help meet health-related needs of Members who are invited and agree to participate in the Care Management Program.

The Administrator's Care Management programs are confidential and voluntary. These programs are provided at no additional cost to You and do not affect Covered Services in any way. Licensed health care professionals trained in care management and familiar with the benefit plan provide these services.

For Members who meet program requirements/criteria and who agree to participate in a Care Management program, a licensed health care professional completes an assessment and develops an individualized plan designed to help meet their identified health care related needs. This is achieved through communication, and collaboration with the Member and/or Member's designated representative, treating Physician(s), and other Providers. The licensed health care professional remains in contact with the Member by telephone on a periodic basis to help accomplish the goals of the plan.

In addition to coordinating benefits, the licensed health care professional may assist with coordination of care with existing community-based programs and services to meet the Member's needs. Care coordination may include referrals to external agencies and available community-based programs and services.

Value-Added Programs

The Administrator, on behalf of CEBCO, may offer health or fitness related programs to the Plan's 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 the Plan and could be discontinued at any time. The 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

Claims Payment

When you receive care through a Network Provider, you are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

A claim must be filed for you to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit your claim for you. If you submit the claim, use a claim form.

How Benefits Are Paid

Maximum Allowable Amount

General

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

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement the Plan 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 Benefit Booklet.

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 a Non-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 Provider, the 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 Administrator's determination of the Maximum Allowed Amount. The Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

Provider Network Status

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

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with the Administrator. For

Covered Services performed by a Network Provider, the Maximum Allowed Amount for this/your Plan is the rate the Provider has agreed with the 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 Customer Service for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Administrator and are not in any of the Administrator's networks are Non-Network Providers.

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

1. An amount based on the Administrator's Non-Network Provider fee schedule/rate, which the Administrator has established in its' discretion, and which the 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 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 the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by the 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 equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods shown above.

Providers who are not contracted for this product, but are contracted for other products with the Administrator are also considered Non-Network. For this/your Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Administrator and that Provider specifies a different amount.

Unlike Network Providers, Non-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 Customer Service for help in finding a Network Provider or visit the Administrator's website at www.anthem.com.

Customer Service is also available to assist You in determining this/your Plan's Maximum Allowed Amount for a particular service from a Non-Network Provider. In order for the 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 Customer Service 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 Limits may vary depending on whether You received services from a Network or Non-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on your benefits when using Non-Network Providers. Please see the Schedule of Benefits in this Benefit Booklet for your cost share responsibilities and limitations, or call Customer 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 a Network or Non Network Provider. Both services specifically excluded by the terms of your Plan and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances You may only be asked to pay the lower Network cost sharing amount when You use a Non-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is not employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Benefit Booklet's cost share amounts; see Your Schedule of Benefits for Your applicable amounts.

Example: Your plan has a Coinsurance cost share of 20% for Network services, and 30% for Non-Network services after the Network or Non-Network Deductible has been met.

You undergo a surgical procedure in a Network Hospital. The Hospital has contracted with a Non-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Non-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; Your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from the Plan is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total Out of Pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*
- You choose a Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; Your Coinsurance responsibility when a Network surgeon is used is 20% of \$1500, or \$300. The Plan allows 80% of \$1500, or \$1200. The Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.*
- You choose a **NON-NETWORK** surgeon. The Non-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; Your Coinsurance responsibility for the NON-NETWORK surgeon is 30% of \$1500, or \$450 after the NON-NETWORK Deductible has been met. The Plan allow the remaining 70% of \$1500, or \$1050. **In addition**, the Non-Network surgeon could bill You the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.*

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 a Non-Network Provider. In such circumstance, You must contact the Administrator in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share

amounts to apply to a claim for Covered Services if You receive Emergency services from a Non-Network Provider and are not able to contact the Administrator until after the Covered Service is rendered. If the Plan authorizes a Covered Service so that You are responsible for the Network cost share amounts, You may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Benefit Booklet's cost share amounts; see Your Schedule of Benefits for Your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no Network Provider for that specialty in your state of residence. You contact the Administrator in advance of receiving any Covered Services, and the Plan authorizes You to go to an available Non-Network Provider for that Covered Service and the Plan agrees that the Network cost share will apply.

Your plan has a \$45 Copayment for Non-Network Providers and a \$25 Copayment for Network Providers for the Covered Service. The Non-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because the Plan has authorized the Network cost share amount to apply in this situation, You will be responsible for the Network Copayment of \$25 and the Plan will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.

Because the Non-Network Provider's charge for this service is \$500, You may receive a bill from the Non-Network Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with your Network Copayment of \$25, your total out of pocket expense would be \$325.

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 Allowable Amount. **If services are performed by Non Network Providers**, then you are responsible for any amounts charged in excess of the Plan's Maximum Allowable Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact the Administrator for more information.

Payment of Benefits

You authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under CEBCO's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, the Plan will not honor a request to withhold payment of the claims submitted.

Notice of Claim

The Plan is not liable, unless the Administrator receives written notice that Covered Services have been given to you. The notice must be given to the Administrator, on behalf of CEBCO, within 90 days of receiving the Covered Services, and must have the data the Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Administrator needs to process the claim, then the necessary data must be submitted to the Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If the Administrator has not received the information it needs to process a claim, the Administrator will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, the Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator, on behalf of CEBCO, generally will make its request for additional information within 30 days of the Administrator's initial receipt of the claim and will complete the Administrator's processing of the claim within 15 days after the Administrator's receipt of all requested information. An expense is considered incurred on the date the service or supply was given. **If the Administrator is unable to complete processing of a claim because you or your Provider fail to provide the Administrator with the additional information within 60 days of its request, the claim will be denied and you will be financially responsible for the claim.**

Failure to give the Administrator notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to the Administrator, or contact customer service and ask for claim forms to be sent to you. If you do not receive the claim forms, written notice of services rendered may be submitted to the Administrator without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits (EOB)

After you receive medical care, you will generally receive an explanation of benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from the Plan 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).
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

BlueCard Program

When you obtain health care services through the BlueCard Program outside the geographic area the Administrator serves, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto the Administrator, on behalf of CEBCO.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Administrator, on behalf of CEBCO would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

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 Non-Network care and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card or go to www.anthem.com for more information about such arrangements.

General Provisions

Entire Agreement

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

Form or Content of Benefit Booklet

No agent or employee of the Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of CEBCO.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Administrator, CEBCO, nor any Provider shall have any further responsibility to pay benefits or provide care for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

The Administrator, on behalf of CEBCO, shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Administrator or CEBCO, 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 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 Administrator, on behalf of CEBCO, shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the 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 CEBCO's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As an 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 customer service number on the back of your Identification Card.

Coordination of Benefits

This Coordination of Benefits (“COB”) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern 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 in accordance with its policy terms without regard to 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.

Definitions

- A 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, health insuring corporation (“HIC”) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate 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, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one 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 the person has 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 the person. 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 the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense.

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

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If a person is covered by 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 a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans.

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

5. The amount of any benefit reduction by the Primary plan because a Member has 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, and preferred provider arrangements.
 6. The amount that is subject to the Primary high-deductible health plan's deductible, if the 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 to Members primarily in the form of services through a panel of providers which have contracted 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 a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation 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 shall 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 superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A 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.

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

- (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
- (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The 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.
 - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), the Administrator will follow the rules of that plan.
 - (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the 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;
 - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The 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.
 - (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

- (4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other 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 the rule labeled D(1) can determine the order of benefits.
- (5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect On The Benefits Of This Plan

- When 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. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- If a Member is 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 shall 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 Administrator may get the facts it needs from them or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. The Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give the Administrator any facts it 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, the 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. The Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

Coordination Disputes

If you believe that the Plan has not paid a claim properly, you should attempt to resolve the problem by contacting the Administrator. Follow the steps described in the "**Complaint and Appeals Procedures**" section of this Benefit Booklet.

Medicare

Any benefits covered under both the Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under the 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 payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Member to the Plan, to the extent the Plan has made payment for such services.

Physical Examination

The Administrator, on behalf of CEBCO, reserves the right to cause you to be examined by an applicable Provider as often as may be reasonably required during the pendency of a claim.

Worker's Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's 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 Worker's Compensation.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, 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.

Subrogation and Right of Reimbursement

These provisions apply when Plan benefits are paid as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

The Administrator, on behalf of CEBCO, has the right to recover Plan payments made on your behalf from any party responsible for compensating you for your injuries. The following apply:

- The Administrator, on behalf of CEBCO, has the first priority for the full amount of benefits they have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable the Administrator, on behalf of CEBCO, to exercise their rights and do nothing to prejudice them.
- The Administrator, on behalf of CEBCO, has the right to take whatever legal action they see fit against any party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Administrator's subrogation claim and any claim still held by you. The Administrator'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 Administrator, on behalf of CEBCO, is not responsible for any attorney fees, other expenses or costs without its prior written consent. The Administrator, on behalf of CEBCO, further agrees that 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 Administrator, on behalf of CEBCO.

Reimbursement

If you obtain a Recovery and the Administrator, on behalf of CEBCO, has not been repaid for the benefits the Administrator, on behalf of CEBCO, paid on your behalf, the Administrator, on behalf of CEBCO, shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse the Administrator, on behalf of CEBCO, to the extent of Plan benefits the Administrator, on behalf of CEBCO, paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Administrator, on behalf of CEBCO, shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the Administrator, on behalf of CEBCO, the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Administrator, on behalf of CEBCO, immediately upon your receipt of the Recovery. You must reimburse the Administrator, on behalf of CEBCO, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Administrator, on behalf of CEBCO.
- If You fail to repay the Administrator, on behalf of CEBCO, the Administrator, on behalf of CEBCO, shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Administrator, on behalf of CEBCO, has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
 1. The amount the Administrator, on behalf of CEBCO, paid on your behalf is not repaid or otherwise recovered by the Administrator, on behalf of CEBCO; or
 2. You fail to cooperate.
- In the event that you fail to disclose to the Administrator and/or CEBCO the amount of your settlement, the Administrator, on behalf of CEBCO, shall be entitled to deduct the amount of their lien from any future benefit under the Plan.
- The Administrator, on behalf of CEBCO, shall also be entitled to recover any of the unsatisfied portion of the amount they have paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Administrator, on behalf of CEBCO, has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Administrator, on behalf of CEBCO, would not have any obligation to pay the Provider.
- The Administrator, on behalf of CEBCO, is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify the Administrator, on behalf of CEBCO, promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Administrator, on behalf of CEBCO, in the investigation, settlement and protection of CEBCO's rights of the Administrator, on behalf of CEBCO.
- You must not do anything to prejudice the rights of the Administrator, on behalf of CEBCO.
- You must send the Administrator, on behalf of CEBCO, 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 Administrator, on behalf of CEBCO, if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, the Administrator, on behalf of CEBCO, will have the right to recover such payment from you or, if applicable, the Provider. The Administrator, on behalf of CEBCO, reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Relationship of Parties (CEBCO-Member-Administrator)

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

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

Modifications

This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by CEBCO, or by mutual agreement between the Administrator and CEBCO 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.

Conformity with Law

Any provision of this Plan which is in conflict with the state in which the Benefit Booklet is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Clerical Error

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

Policies and Procedures

CEBCO is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules and interpretations.

Under the terms of the Administrative Services Agreement, the Administrator has the authority, in its sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Benefit Booklet. The Administrator reserves the right to discontinue a pilot or test program at any time. The Administrator will provide advance written notice to CEBCO of the introduction or termination of any such program.

Waiver

No agent or other person, except an authorized officer of CEBCO, 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.

CEBCO's Sole Discretion

CEBCO may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if CEBCO, with advice from the 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

Anthem shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Complaints and Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or Exclusion will override more general benefit language. Anthem's determination shall be final and conclusive and may include, without limitation, determination or 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 Allowable Amount. A Member may utilize all applicable Complaint and Appeals procedures.

Community Insurance Company Note

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

Complaint and Appeals Procedure

The Administrator's customer service representatives are trained to answer your questions about your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Copayment or Coinsurance amounts,
- Specific claims or services you have received,
- Doctors or Hospitals in the Network,
- Authorizations; and/or
- Provider directories.

Complaint and Appeal procedure have been established to provide fair, reasonable, and timely solutions to complaints that you may have concerning the Plan. The Plan invites you to share any concerns that you may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical Providers in the Administrator's Networks.

The Complaint Procedure

If you have a complaint, problem, or claim concerning benefits or services, please contact the Administrator. Please refer to your Identification Card for the Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Administrator of their procedures and your benefit document. You may submit your complaint by letter or by telephone call. If your complaint involves issues of Covered Services, you may be asked to sign a release of information form so the Administrator can request records for their review.

You will be notified of the resolution of your complaint if a claim or request for benefits is denied in whole or in part. The Administrator will explain why benefits were denied and describe your rights under the Appeal Procedure.

Appeal Procedures

As a Member of this Plan you have the right to appeal decisions to deny or limit your health care benefits. The explanation of why the Administrator denied your claim or request for benefits will describe the steps you should follow to initiate your appeal.

An appeal is a request from you for the Administrator to change a previous determination or to address a concern you have regarding confidentiality or privacy.

Internal Appeals

An initial determination by the Administrator can be appealed for internal review at two subsequent levels known as "Level 1" and "Level 2" appeals. The Administrator will advise you of your rights to appeal to the next level if a denial occurs after an initial determination or Level 1 appeal.

You have the right to designate a representative (e.g. your Physician) to file appeals with the Administrator on your behalf and to represent you in any level of the appeals process. If a representative is seeking an appeal on your behalf, the Administrator must obtain a signed Designation of Representation (DOR) form from you. The appeal process will not begin until the Administrator has received the properly completed DOR form except that if a Physician requests expedited review of a Level 1 appeal on your behalf, the Physician will be deemed to be your designee for the limited purpose of filing for expedited review of the Level 1 appeal without receipt of a signed form. The Administrator will forward a Designation of Representation form to you for completion in all other situations.

The Administrator will accept oral or written comments, documents or other information relating to an appeal from the member or the member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

To obtain information on the Plan's appeal procedures or to file an oral appeal please call the toll free customer service number listed on the back of your Plan Identification Card or the number provided for appeals on any written notice of an adverse decision that you receive from the Administrator.

The Administrator will also accept appeals filed in writing. If you wish to file your appeal in writing, you must mail it to: Anthem Blue Cross and Blue Shield, P.O. Box 33200, Louisville, Kentucky 40233-3320, or to the address provided for filing an appeal on any written notice of an adverse decision that you receive from the Administrator.

Upon the receipt of your written or oral appeal at the appeals address or telephone number provided above or provided on any notice of an adverse decision, the Administrator will send you an acknowledgment within 5 business days notifying you that you will receive a written response to the appeal once an investigation into the matter is complete. The acknowledgment may be oral for those appeals the Administrator receives orally.

Level 1 Appeals

Level 1 appeals are reviewed by persons who did not make the initial determination and who are not the subordinates of the initial reviewer. If a clinical issue is involved, the Administrator will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review your medical records and determine if the service is covered by your benefit document. If the clinical peer determines that the service is covered by your benefit document the Administrator must pay for the service; if the clinical peer determines that the service is not covered the Administrator may deny the services.

If you are appealing an adverse precertification decision other than a retrospective post-claim review decision (i.e., an adverse prospective, concurrent or retrospective pre-claim review decision) or the denial of any prior approval required by the Plan, the Administrator will provide you with a written response indicating the Plan's decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days of the date the Administrator receives your Level 1 appeal request. If more information is needed to make a decision on your Appeal, the Administrator will send a written request for the information after receipt of the Appeal. No extensions of time for additional information may be taken on these Appeals without the permission of the member. Therefore, the Administrator will make a decision based upon the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the Appeal, the Administrator will provide you with a written response indicating the decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days from receipt of the Appeal request. If more information is needed to make a decision on your Appeal, the Administrator shall send a written request for the information after receipt of the Appeal. If the additional information requested is not received within 30 calendar days of the Appeal request, the Administrator shall conduct its review based upon the available information.

Level 2 Appeals

If the Plan's Level 1 appeal decision is satisfactory to you, the matter is concluded. If the Plan's decision is not satisfactory, you or your designated representative may initiate a voluntary Level 2 appeal by contacting the Administrator either in writing or by phone at the above address and telephone numbers. An acknowledgment will be sent to you within 5 business days upon the Administrator's receipt of your Level 2 appeal request. At Level 2, the appeal is reviewed by a panel of the Plan's staff members. The Administrator will set a date and time during normal business hours for the Plan appeal panel members to meet to discuss your Level 2 appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not You choose to appear in person or by telephone.

Level 2 appeals concerning adverse precertification decisions other than retrospective post-claim review decisions (i.e., adverse prospective, concurrent or retrospective pre-claim review decisions) or the denial of any prior approval required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Level 2 appeal request was received by the Administrator. All other Level 2 appeals will be resolved by the panel no later than 45 business days from the date your Level 2 appeal request was received by the Administrator.

After the appeal panel makes a decision you will be notified within 5 business days in writing by the Administrator of the Plan's decision concerning your Level 2 appeal.

Expedited Reviews

Expedited Review of a Level 1 appeal, or Level 2 appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available only if the medical care for which coverage is being denied has not yet been rendered. The Administrator will complete expedited review of a Level 1 appeal as soon as possible given the medical exigencies but no later than within seventy-two hours (72 hours) of receipt of sufficient information and will communicate the Plan's decision by telephone to your attending Physician or the ordering Provider. The Administrator will also provide written notice of the Plan's determination to you, your attending Physician or ordering Provider, and the facility rendering the service. The Administrator will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and Panel administration permits. The Plan's decision will be communicated by telephone to your attending Physician or the ordering Provider. The Administrator will also provide written notice of the Plan's determination to you, your attending Physician or ordering Provider, and to the facility rendering the service.

You may request an expedited review if a Provider with knowledge of your medical condition certifies that the absence of immediate medical attention will do any of the following:

- Place the health of the patient or unborn child in serious jeopardy,
- Cause serious impairment to bodily functions,
- Cause serious dysfunction of any body organ or part,
- Subject you to severe pain that cannot be adequately managed.

The Plan, by applying a prudent lay person standard, may also determine that an appeal may be expedited.

External Appeals

If the Plan continues to deny benefits for the service, you may request a review from another source. You may appeal issues for any of the reasons listed below:

- They are not Medically Necessary.
- They are Experimental/Investigative.

A Member may proceed with an expedited external review while simultaneously pursuing an appeal through the Administrator's Level 1 internal appeal process for requests regarding urgent care services or ongoing treatment.

Denial Because Services are Not Medically Necessary or are Experimental/Investigative

If the Plan denies benefits for a service because it is not Medically Necessary according to your health plan coverage and the service and related expenses will cost you more than \$500 or the service has not been incurred yet and non-receipt of the service would jeopardize your life or health, you may request the Plan to obtain an external review from an independent review organization (IRO). Regardless of the cost of the service at issue, you may also request external review if the Plan denies benefits for any service or supply because it is Experimental/Investigative. The IRO is not affiliated with the Plan. The Plan pays the cost for the IRO review.

You must request this review from the Administrator within 180 days of receiving notice of the result of the internal review of your appeal. Your request must be in writing except that if your Physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for external review is made, written confirmation of the request must be submitted to the Administrator no later than 5 business days after the oral or electronic request is made.

The IRO will review your medical records and other relevant information to determine if the service for which benefits are requested is Medically Necessary or not Experimental/Investigative. If the IRO determines that the service is Medically Necessary or not Experimental/Investigative, the Plan must provide benefits for the service according to the

terms of your benefit document. If the IRO determines that the service is not Medically Necessary, the Plan does not have to provide benefits for the service.

To qualify for this review you must meet all of the following criteria.

- You request an external review from the Administrator not later than 180 days after receipt of notice from the Administrator of the result of the Plan's internal review.
- You have exhausted all levels of our internal review process, with the exception of external reviews requested concurrently to the Administrator's internal process.
- The drug, device, procedure, or other therapy would be covered if it were not considered to be Experimental or Investigational.

Instructions For Requesting An External Review by an IRO

You (the Member) or your designated representative, may request an external review.

Your request for an external review must be submitted within 180 days after receiving notice from the Administrator of the denial of the Plan's internal review. The Plan will pay for the external review.

External review will be performed by an independent review organization (IRO). The IRO must provide the Administrator with a response to your request for an external review within 30 days for a standard review or 7 days for cases meeting expedited review criteria. The IRO's decision must include:

- A description of the patient's condition,
- The principal reasons for the decision,
- An explanation of the clinical rationale for the decision.

If the IRO determines that the service should be covered by the Plan, the Plan must pay for the service according to the terms of your benefit document. If the IRO determines that the service should not be covered by the Plan, the Plan does not have to pay for the service.

Definitions

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Actively At Work - Present and capable of carrying out the normal assigned job duties of CEBCO. Subscribers who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation will be considered Actively At Work.

Administrative Services Agreement - The agreement between the Administrator and CEBCO regarding the administration of certain elements of the health care benefits of CEBCO's Group Health Plan.

Administrator - An organization or entity that CEBCO contracts with to provide administrative and claims payment services under the Plan. The Administrator is Community Insurance Company. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Alternate Recipient - Any child of a Subscriber who is recognized under a Qualified Medical Child Support Order (QMSCO) as having a right to enrollment under the Plan with regard to such Subscriber.

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

Behavioral Health Conditions –

- **Mental Health Condition** – A display of mental or nervous symptoms that are not a result of any physical or biological cause(s) or disorder(s).
- **Substance Abuse** – A condition that develops when an individual uses alcohol or other drug(s) in a way that damages their health and/or causes them to lose control of their actions.

Benefit Booklet - This summary of the terms of your health benefits.

Benefit Period - The period of time that benefits for Covered Services are payable under the Plan. The Benefit Period is listed in the Schedule of Benefits. If your benefits end earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum that the Plan will pay for specific Covered Services during a Benefit Period.

CEBCO - The legal entity contracting with the Administrator for administration of group health care benefits.

Copayment – A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. The Copayment does not apply to any Deductible that you are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or amount charged by the Provider.

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies to the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.

Covered Services - Services, supplies or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Benefit Booklet.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance by the Administrator, on behalf of CEBCO, if such Precertification/Prior Authorization is required in this Benefit Booklet.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in benefits after termination.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by the Plan including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member’s appropriateness for a Covered Transplant Procedure.

Creditable Coverage - Prior coverage from a Group plan, Medicare, Medicaid, Indian Health Service, state risk pool, public health plan, individual insurance policy or Peace Corps service. Prior coverage does not count as Creditable Coverage if there was a break in coverage of 63 days or more prior to enrolling for benefits under the Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Deductible - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before benefits are payable under the Plan for Covered Services each Benefit Period.

Dependent - A person of the Subscriber’s family who is eligible for coverage under the Plan as described in the Eligibility and Enrollment section.

Diagnostic (Service/Testing) – A test or procedure performed on a Member, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a Member who is not displaying any symptoms. However, this must be ordered by a Provider. Examples of covered Diagnostic Services in the Covered Services section.

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

Effective Date - The date your coverage begins under the Plan. You must be Actively At Work on your Effective Date. If you are not Actively At Work on your Effective Date, your Effective Date will be the date you become Actively At Work. A Dependent's coverage under the Plan begins on the Effective Date of the sponsoring Subscriber. No benefits are payable for services and supplies received before your Effective Date or after your termination date.

Eligible Person - A person who satisfies CEBCO’s eligibility requirements and is entitled to apply to be a Subscriber.

Emergency (Emergency Medical Condition) - An accidental traumatic bodily injury or other medical condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- Place an individual's health in serious jeopardy;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care (Emergency Services) - A medical 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 Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.

Enrollment Date - The first day of coverage under the Plan or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

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 Administrator, on behalf of CEBCO, determines to be unproven. For how this is determined, see the “Exclusions” section.

Family Coverage - Coverage provided by CEBCO for the Subscriber and eligible Dependents.

Fee(s) - The periodic charges which are required to be paid by you and/or CEBCO to maintain benefits under the Plan.

Identification Card - A card issued by the Administrator, on behalf of CEBCO, that bears the Member’s name, identifies the membership by number, and may contain information about your benefits under the Plan. It is important to carry this card with you.

Inpatient - A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Late Enrollee - An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under the Plan, and who did not qualify for Special Enrollment.

Maximum Allowable Amount (Maximum Allowed Amount) - The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the “Claims Payment” section.

Medically Necessary or Medical Necessity - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Administrator, on behalf of CEBCO, to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

While the Administrator is allowed by CEBCO to determine whether services or supplies are Medically Necessary, CEBCO is the final authority over Plan benefits.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member - A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by CEBCO and been covered by the required Fee payment; Members are sometimes called "you" or "your" in this Benefit Booklet.

Network Provider - A Provider who has entered into a contractual agreement or is being used by the Administrator, or another organization, which has an agreement with the Administrator, to provide Covered Services and certain administration functions for the Network associated with the Plan.

Network Transplant Provider - A Provider that has been designated as a "center of excellence" by the Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee. 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.

New FDA Approved Drug Product or Technology - The first release of the brand name product or technology upon the initial FDA New Drug Approval or other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations: a new dosage form or new formulation of an active ingredient already on the market;
- Already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- Already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- Newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider - A Provider who has not entered into a contractual agreement with the Administrator for the Network associated with the Plan. Providers who have not contracted or affiliated with the Plan's designated Subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers.

Non-Network Transplant Provider - Any Provider that has **NOT** been designated as a “center of excellence” by the Administrator or has not been selected to participate as a Network Transplant Provider by a designee.

Out-of-Pocket Limit - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this Certificate and/or the Schedule of Benefits.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Plan - The group health benefit plan provided by CEBCO and explained in this Benefit Booklet.

Pre-Existing Condition - A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 Months period ending on your Enrollment Date. Pregnancy and domestic violence are not considered Pre-Existing Conditions. Genetic information may not be used as a condition in the absence of a diagnosis. Pre-Existing exclusions or limitations do not apply to Member's under the age of 19.

Primary Care Physician (“PCP”) – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network 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.

Provider – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID card.

- **Alcoholism Treatment Facility** - A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternative Care Facility** – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:
 1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI).
 2. Surgery.
 3. Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** - A facility, with an organized staff of Physicians, that:
 1. Is licensed as such, where required;
 2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
 3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
 4. Does not provide Inpatient accommodations; and
 5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Certified Advance Registered Nurse Practitioner**

- **Certified Nurse Midwife**
- **Clinical Nurse Specialists whose nursing specialty is Mental Health.**
- **Certified Registered Nurse Anesthetist**
- **Certified Surgical Assistant**
- **Day Hospital** - A facility that provides day rehabilitation services on an Outpatient basis.
- **Dialysis Facility** - A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.
- **Drug Abuse Treatment Facility** - A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency** - A facility, licensed in the state in which it is located, which:
 - Provides skilled nursing and other services on a visiting basis in the Member's home; and
 - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Home Infusion Facility** - A facility which provides a combination of:
 1. Skilled nursing services
 2. Prescription Drugs
 3. Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.
- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
 1. Provides room and board and nursing care for its patients;
 2. Has a staff with one or more Physicians available at all times;
 3. Provides 24 hour nursing service;
 4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
 5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

7. Treatment of alcohol abuse
8. Treatment of drug abuse

- **Independent Social Workers**
- **Laboratory (Clinical)**
- **Licensed Practical Nurse**
- **Licensed Professional Counselors**
- **Occupational Therapist**
- **Outpatient Psychiatric Facility** - A facility which mainly provides Diagnostic and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.
- **Physical Therapist**
- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiroprapist (surgical foot specialist) or optometrist (eye and sight specialist).
- **Professional Clinical Counselors**
- **Professional Counselors**
- **Psychiatric Hospital** - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Registered Nurse First Assistant**
- **Registered Nurse**
- **Registered Nurse Practitioner**
- **Regulated Physician's Assistant**
- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Respiratory Therapist (Certified)**
- **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.
- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
 2. provides care supervised by a Physician;
 3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
 4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
 5. is not a rest, educational, or custodial Provider or similar place.
- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
 - **Speech Therapist**
 - **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**
 - **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist," "Underinsured Motorist," "Medical-Payments," "No-Fault," or "Personal Injury Protection," or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Benefit Booklet.

Service Area - The geographical area within which Covered Services under the Plan are available.

Single Coverage - Coverage for the Subscriber only.

Specialty Care Physician (SCP) - A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Stabilize - The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- Your transfer from an emergency department or other care setting to another facility; or
- Your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor - The Administrator, on behalf of CEBCO, may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to mental health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on CEBCO's behalf.

Subscriber - An eligible employee or retired employee or member of CEBCO enrolled under the Plan, whose benefits are in effect and whose name appears on the Identification Card issued by the Administrator, on behalf of CEBCO.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the Covered Services section.