US AIRWAYS, INC. HEALTH OPTIONS PLAN

Summary Plan Description

Effective January 1, 2012

SUMMARY PLAN DESCRIPTION

This document summarizes the main provisions of the US Airways, Inc. Health Options Plan (Plan), effective as of January 1, 2012, and serves as the Summary Plan Description (SPD) for medical, prescription drug, behavioral health and chemical dependency benefits under the Plan. In this SPD you will find descriptions of those benefits as they apply to eligible employees and their eligible Dependents.

This SPD provides a comprehensive overview of the benefits available under the Plan, as well as limitations, exclusions, deductible and coinsurance requirements. Additional Plan details are contained in the legal Plan document. If there is any difference between the information in this SPD and the legal Plan document, the legal Plan document will govern. US Airways, Inc. (US Airways or the Company) sponsors the Plan and reserves the right to amend or terminate the Plan at any time. You will be notified of any changes that affect your benefits, as required by federal law.

This is not an insured benefit plan. The benefits described in this SPD are funded by US Airways, who is responsible for their payment. Anthem Blue Cross Blue Shield (Anthem) has been designated by US Airways to provide administrative services for the medical, behavioral health and chemical dependency benefits under the Plan, including claims processing, care management, and other services, and to arrange for a network of health care providers whose services are covered by the Plan. CVS Caremark, Inc. (CVS) has been designated by US Airways to provide administrative services for the prescription drug coverage under the Plan.

Terms used to describe your benefits are generally defined when the term is first introduced. There is also a “Definitions” Section at the end of this SPD that defines certain additional terms and how they apply to the benefits described in this SPD.

Please read this SPD carefully and share it with your family members who are eligible for coverage or for whom you’ve elected coverage. If you have any questions about the benefits information contained in this SPD, contact Benefits US Customer Service at 1-888-860-6178.

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ELIGIBILITY

Eligibility for You

You are eligible to participate in the Plan if you are an active full-time or part-time employee of the Company with a work base in the United States, but excluding any temporary, on-call or seasonal employees. For new hires, the date participation in the Plan begins differs based on your work group. *(See the "When Coverage Begins" Section of this SPD for more information.)*

Please note: For purposes of eligibility, "employees" are individuals who are classified by the Company as employees under Section 3121(d) of the Internal Revenue Code. In the event the classification of an individual who is excluded from eligibility under the preceding sentence is determined to be erroneous or is retroactively revised by a court, administrative agency or other administrative body, the individual shall nonetheless continue to be excluded from the Plan and shall be ineligible for benefits for all periods prior to the date that it is determined that its classification of the individual is erroneous or should be revised.

Former employees of the Company are considered eligible for coverage under the Plan solely for purposes of electing and receiving continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Generally, such coverage is only available to former employees of the Company who were covered under the Plan as active employees the day before their separation from service with the Company. (*See the "When Coverage Terminates" Section of this SPD for information about COBRA.*)

Eligibility During a Leave of Absence or Furlough

If you take a Company-approved leave of absence, you may continue, start or stop participation in the Plan, at the beginning of the leave of absence and also upon your return from the leave of absence provided you are still eligible to participate in the Plan at that time. If you make no changes to the medical elections in place for you (and your Dependents) before a leave of absence begins, those elections will remain in place until the earliest of (a) the date you make an election change due to a change in status event *(see the "Making Changes During the Year" Section of this SPD for more information on change in status events)*, (b) the date you stop making any required premium payments, or (c) the date you (or your Dependents) are no longer eligible for coverage under the Plan. If you waive medical coverage at the beginning of or during a leave of absence or furlough, you will not be able to re-enroll for medical coverage until you return to active status or retire.

During a leave of absence or furlough, you may participate in annual enrollment for the limited purpose of reducing your level of coverage or waiving coverage. You may not enroll additional Dependents for coverage under the Plan unless you experience a change in status event *(see the "Making Changes During the Year" Section of this SPD for more information on change in status events)*.

If you go on furlough, you are eligible to continue your participation in your Company-sponsored medical coverage according to the terms specified in your collective bargaining agreement. Please see the collective bargaining agreement applicable to you for more details. You can obtain a copy of your collective bargaining agreement by contacting your local management or union representative.

Eligibility for Your Dependents

You may elect coverage for your eligible Dependents under the Plan, provided you enroll them and supply the necessary documentation to verify eligibility. Eligible Dependents include:

- Your Spouse (or domestic partner) *(see the "Domestic Partners" Section of this SPD for eligibility requirements)*;

- Your children who are age 26 and under at any time in a calendar year;

- The children of your domestic partner who are age 26 and under at any time in a calendar year, even if you do not elect coverage for your domestic partner; and

- The unmarried children of you or your domestic partner following the calendar year in which they attain age 26 who are not self-supporting because of a permanent physical, or mental disability and are dependent upon you, as defined by the Internal Revenue Code for income tax purposes, provided that such child was physically or mentally disabled and covered by the Plan on the day before the end of the calendar year in which they attained age 26. Any child who satisfies these conditions will continue to be eligible for coverage as long as the disability remains. The Plan Administrator may require documentation that confirms such child's ongoing disability. "Disability" for dependent eligibility purposes will have the meaning used by the Internal Revenue Service for income tax purposes.

Children, for purposes of determining those dependents who are your "eligible dependent children" under the Plan, include:

- Your biological child, legally adopted child for whom you have permanent legal guardianship, a child placed with you for adoption, or your stepchild;

- Your domestic partner's biological child, legally adopted child for whom your domestic partner has legal guardianship, a child placed with your domestic partner for adoption, or stepchild of your domestic partner.

Supporting Documentation for Eligible Dependent Children

The Company will require you to provide supporting documentation for eligible Dependent children and for other Dependents. This information includes verification of relationship. If you fail to provide this information at the time Dependents are added, they will not be eligible to receive coverage under the Plan. Receipt of Identification Cards issued by Anthem does not guarantee coverage. When your Dependent children are no longer eligible to participate in the Plan, you must notify the Benefits US Customer Service.

Coverage for a verified domestic partner or children who are not "tax dependents" (or otherwise able to receive tax-free coverage up to age 26) under the Internal Revenue Code will result in taxable income for you. If your domestic partner or your domestic partner's children satisfy the requirements to be considered your tax dependents, you may submit a signed "Dependent Certification Form" to the Benefits Department to certify dependent status and avoid this taxable income. This form must be submitted each year by no later than December 1st if you wish to avoid this taxable income. For further information regarding these issues, please see the Section of this SPD entitled "*Paying for Coverage for Domestic Partners and Their Children*." You may also wish to consult your tax advisor to determine how these IRS rules will impact your personal situation.

Domestic Partners

For purposes of the Plan, a domestic partner is an individual who meets all of the requirements outlined in this Section. Eligibility for your domestic partner and your domestic partner's children ends on the date a domestic partner no longer meets these requirements.

A domestic partner is your partner of the same gender who is:

- At least 18 years old;

- Not married to anyone other than yourself, and has dissolved any prior marriages through death or divorce;

- Not related to you by a degree of closeness that would prohibit legal marriage in the state(s) or domicile where you and your domestic partner reside;

- Your sole domestic partner for at least the last six months and is responsible for your common welfare and financial obligation, just as you are responsible for his or hers; and

- One who currently shares a household with you that is the primary residence for both of you and who has done so for the last six months (although you may live apart for reasons of education, health care, work, or military service).

You must demonstrate a valid domestic partnership to the Company in order to elect coverage for your domestic partner or your domestic partner's children. To do so, you must submit documentation that satisfies one of the following categories:

- A marriage certificate from a state or locality that allows or allowed same gendered marriage (provided such marriage has not subsequently been dissolved by the parties);

- Proof of domestic partner registration in a state or locality that allows for registration of domestic partner relationships (provided such registration has not subsequently been dissolved by the parties);

- An executed *Affidavit of Domestic Partnership* (which may be made available to you by the Company); or

- Two items, one from List A and one from List B below, with respect to both partners, one dated within two months of your eligibility date for the Plan and one dated at least 6 months prior to your eligibility date for the Plan:

List A	**List B**
■ A joint mortgage, lease, or deed	■ Joint bank account, joint credit cards, or other evidence of joint financial responsibility
■ Designation of the domestic partner to act on each other's behalf for all purposes under a power of attorney	■ Designation of the domestic partner as primary beneficiary for life insurance, retirement benefits, or a legal will or trust

You and your eligible domestic partner must be aware of and understand the nature of the domestic partnership registration with the Company.

Confidentiality of Supporting Documentation for Domestic Partners

The Company will maintain the confidentiality of these documents, except as required to administer the benefits provided to eligible domestic partners, and except as required by law or in connection with legal proceedings involving the Plan.

If You and Your Spouse (or Domestic Partner) Both Work for the Company

In the case where you and your Spouse (or domestic partner) are both employed by the Company, provided you meet all other eligibility requirements, you may participate in the Plan in one of the following ways:

- You and your Spouse (or domestic partner) may each elect coverage separately; or
- One of you can elect employee coverage and enroll the other as a Dependent (if a Spouse) or a domestic partner.

If you both elect separate coverage, you may either enroll your eligible children as Dependents under your coverage, or enroll them under your Spouse's (or domestic partner's) coverage. You may not, however, enroll them under both your coverage and your Spouse's (or domestic partner's) coverage.

Unless you submit a signed "Dependent Certification Form" to the Benefits Department to certify that your domestic partner and/or your domestic partner's children satisfy the requirements to be considered your tax dependents, domestic partners and their children for whom you elect coverage will not be recognized under this Plan as dependents eligible for tax-free coverage. Therefore, if you elect coverage for them, premiums allocated for their coverage must be paid on an after-tax basis and the value of the Company-paid portion of their coverage will be taxable income to you. Please keep this in mind when making decisions about enrolling domestic partners and their children under your coverage where both you and your domestic partner work for the Company.

When Coverage Begins

Annual Enrollment

You may elect coverage or make changes to your existing elections during the annual enrollment period, provided coverage remains available under this Plan and you continue to be eligible. New elections and any changes made during annual enrollment will be effective on the January 1st immediately following the annual enrollment period and remain in effect through December 31st. Aside from this annual enrollment period, Internal Revenue Service rules specify that you can only make changes to your elections during the year if you experience a change in status event. *(See the "Making Changes During the Year" Section of this SPD for further details.)*

During the annual enrollment period, you may make changes to your Plan elections. For example, you may:

- Add or drop medical coverage; or
- Increase or reduce the number of eligible Dependents you enroll for medical coverage (however, you must provide the required documentation to verify their eligibility for coverage as your Dependent).

During a leave of absence or furlough, you may participate in annual enrollment for the limited purpose of reducing your level of coverage or waiving coverage. Unless you make such changes during the annual enrollment period, coverage under the Plan will continue based on your existing elections. You may not enroll additional Dependents for coverage under the Plan unless you experience a change in status event *(see the "Making Changes During the Year" Section of this SPD for more information on change in status events)*.

New Employee

For most workgroups, except as noted in the next paragraph, employees are eligible to participate in the Plan as of their date of hire. For new hires that are not PHX based pilots and flight attendants, coverage for you and any eligible Dependents you elect to enroll in the Plan will begin on the later of the effective date of the Plan (January 1, 2012) or your date of hire. You have 31 days from your date of hire to enroll in the Plan.

PHX based pilots and flight attendants are eligible to participate in the Plan 90 days following their date of hire. For new hires that are PHX based pilots and flight attendants, coverage for you and any eligible Dependents you elect to enroll in the Plan will begin on the later of the effective date of the Plan (January 1, 2012) or the first of the month following 90 days from your date of hire. You have 31 days from your eligibility date (e.g., the first of the month following 90 days from your date of hire) to enroll in the Plan.

Your initial coverage election will remain in effect as long as you are eligible for coverage under the Plan, or until you make a change to your coverage election during annual enrollment or as the result of a change in status event. If, after you are hired, you do not enroll within 31 days of the date you become eligible to participate in the Plan, you cannot enroll in the Plan until the next annual enrollment or if you experience a change of status event. *(See the "Making Changes During the Year" Section of this SPD for more information on change in status events.)*

Coverage Levels

When you enroll in the Plan, you may choose from one of the following medical coverage levels for you and/or your verified eligible Dependents:

- Employee only;
- Employee and Spouse (or domestic partner);
- Employee and child or children with no Spouse or domestic partner; or
- Employee and family, which includes you, your Spouse (or domestic partner) and your eligible Dependent children.

If You Do Not Enroll for Coverage

If you do not enroll in the Plan when you first become eligible, or during the annual enrollment period, you will **not receive coverage under the Plan**. You will not be eligible to enroll in the Plan until the next annual enrollment period, unless you experience a change in status event. *(See the "Making Changes During the Year" Section of this SPD for more information on change in status events.)*

Paying for Coverage

You share in the cost of your medical coverage with the Company. In general, the Company determines your portion of the contribution costs prior to the beginning of each Plan Year (the 12-month period, beginning each January 1st), based on an evaluation of expected medical administrative and claim expenses for the upcoming year.

Each year before the annual enrollment period, you'll have access to information about the options and coverage levels available to you, and the associated costs through the Benefits US Customer Service website at www.ebenefitsUS.com

If you are an active employee, you will pay for the medical coverage that you elect, by payroll deduction on a pre-tax basis, that is, before Federal—and, in most cases, state—income taxes and Social Security (FICA) taxes are withheld. The amount of your monthly contributions for coverage under the Plan is based on a group rate — that is, it is based on the cost of providing medical coverage to all participants.

If you are on an unpaid Company approved leave of absence or furlough, your payment will be made to a third party administrator on an after-tax basis.

If you cover your domestic partner under the Plan, different tax treatment may apply. *(See the "Paying for Coverage for Domestic Partners and Their Children" in the next Section for more information.)*

Paying for Coverage for Domestic Partners and Their Children

Except as noted below, the payroll contributions for your domestic partner's coverage and for his/her eligible Dependent child(ren)'s coverage are deducted on an after-tax basis. Additionally, you must pay taxes on the value of the Company-paid portion of their coverage. The value of the Company-paid portion of such coverage will be added to your income on your pay stubs and W-2, and is subject to ordinary Federal, state, local, FICA and other applicable payroll taxes.

The above rules will not apply if:

- Your domestic partner and/or your domestic partner's children satisfy the requirements to be considered your tax dependents under the Internal Revenue Code, and

- You submit a signed Dependent Certification Form to the Benefits Department to certify dependent status no later than December 1st for each year for which you elect coverage for your domestic partner and/or your domestic partner's children.

The "Dependent Certification Form," which describes the requirements that must be satisfied in order for your domestic partner and/or your domestic partner's children to be considered your tax dependents, is available on the Benefits US Customer Service website at www.eBenefitsUS.com or the US Airways' employee website at http://wings.usairways.com. If you do not submit the Dependent Certification Form to the Benefits Department on or before December 1st for each year for which you elect coverage for your domestic partner and/or your domestic partner's children your domestic partner and your domestic partner's children will not be treated as tax dependents for that year, and coverage will be taxed as described above in the first paragraph of this Section.

Making Changes During the Year Due to a Change in Status

The Internal Revenue Service rules governing payroll deductions on a pre-tax basis prohibit you from making changes to your elections under the Plan during the Plan Year unless one of the following change in status events occurs. If you experience a change in status event, you may make a coverage change that is consistent with your change in status. Change in status events include:

- A change in your legal marital status (e.g., marriage, divorce, death of spouse, or annulment);

  Note: *legal separation does not constitute a change in status event*

- A change in the number of your Dependents (e.g., through the birth, adoption, placement for adoption, or death of a Dependent);

- A change in your, your Spouse's (or domestic partner's), or your Dependent's employment status, including termination or commencement of employment, a strike or lockout, furlough, commencement of (or return from) an unpaid leave of absence, or a change from full-time to part-time status, or vice versa. A change in employment status that does not affect the number of hours you work does not constitute a change in status event;

- Your Dependent meets (or fails to meet) the Plan's dependent eligibility rules; and

- A change in your, your Spouse's (or domestic partner's) or Dependent's place of residence that would prevent access to the Plan's medical network service areas.

You may also be permitted to make changes to your election(s) under the Plan in the event of:

- An eligible employee or Dependent who is not enrolled under the Plan and declined coverage because of coverage under a group health plan or individual coverage loses such coverage;

- A judgment, decree, or order, including a Qualified Medical Child Support Order (QMCSO), resulting from a divorce, annulment or change in legal custody that affects the provision of medical coverage of your Dependent child, or foster child;

- Entitlement (or loss of entitlement) to Medicare or Medicaid benefits. If you, your Spouse (or domestic partner) or your Dependent becomes entitled to Medicare or Medicaid benefits, you may drop or reduce coverage for that individual. Also, if you, your Spouse (or your domestic partner) or Dependent loses entitlement to Medicare or Medicaid benefits, you may commence or increase medical coverage for that individual under the Plan; and

- A significant reduction of coverage for you or your Spouse (or domestic partner) or Dependent that results in the complete loss of coverage, e.g. loss of coverage due to the elimination of a benefit option or due to an overall lifetime or annual limit.

An Overview of Change in Status Events

The following table provides a detailed look at various circumstances that may be considered change in status events under the Plan, as well as what changes to medical elections may be permitted, according to Internal Revenue Service regulations. For further information regarding change of status events, please refer to your Flexible Benefit Plan Summary Plan Description.

What you May do In the Event of :	Medical
An address change that results in a change into or out of your coverage under the PPO network	• May change coverage option and coverage level. Change must be made within 31 days
Marriage	• May enroll or drop coverage for self, Spouse and Dependents within 31 days. • May change coverage option. Documentation is required.
Divorce	• Must drop Spouse within 31 days. • May enroll or drop coverage for self and/or Dependents within 31 days. COBRA coverage is available for dropped Dependents. • May change coverage option. Documentation is required.
Birth of a Child	• May enroll or drop coverage for self, Spouse and Dependents within 31 days. • May change coverage option. Documentation is required.
Adoption/Placement for Adoption or Permanent Legal Guardianship	• May enroll or drop coverage for self, Spouse and Dependents within 31 days. • May change coverage option. Documentation is required.
Spouse Gains Employment/Coverage	• May drop self and Dependents from coverage within 31 days. • May decrease coverage option. Documentation is required.
Spouse Loses Employment/Coverage	• May elect, waive or change coverage level or coverage option within 31 days. • May add Spouse and Dependents. Documentation is required.
Death of Spouse or Dependent	• May elect, waive or change coverage level or coverage option within 31 days. • May add or drop Dependents. Documentation is required.
Change in employment Status – Full-time to Part-time or Part-time to Full-time	• May enroll or drop coverage for, Spouse and Dependents within 31 days. • May not change enrollment for self. • May change coverage option and level.

What you May do In the Event of :	Medical
Going on Leave/Furlough	• May add or delete Spouse, Dependent(s), and/or yourself within 31 days. • May change coverage option and level.
Returning from Leave/Furlough	• May add or delete Spouse, Dependent(s), and/or yourself within 31 days. • May change coverage level and option. If return from leave is same year you went on leave, and no election changes are made within 31 days, elections will continue at same option and level as before your leave.
Rehire	• May add or delete Spouse, Dependent(s), and/or yourself within 31 days. • May change coverage level and option. If rehired in the same year you terminated and no election changes are made within 31 days, elections will continue at same option and level as before your leave.

Special Enrollment Periods

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you will be able to enroll yourself, your Spouse or your Dependents in this Plan if any of three special enrollment periods apply, as described below.

Special Enrollment for Loss of Coverage

A special enrollment period applies if you or a Dependent did not enroll during the annual enrollment period or initial enrollment period (for newly hired employees), provided that you request enrollment within 31 days after your other coverage ends, and the following requirements are satisfied:

- you or your Dependent had existing health coverage (also known as creditable coverage) under another plan at the time of the initial enrollment period or annual enrollment period.

- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including without limitation, divorce or death).
  - The prior employer or policyholder stopped paying the contribution.
  - In the case of COBRA continuation coverage, the coverage ended.

Coverage will become effective as of the first day following the loss of coverage.

Failure to notify the Company of your loss of coverage within 31 days of the loss will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

Special Enrollment for Addition of a Dependent

A special enrollment period applies if you add a Dependent due to marriage, birth, adoption, or placement for adoption, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Coverage added due to marriage, birth, adoption or placement for adoption will become effective as of the date of the event.

Failure to notify the Company of your marriage, birth, adoption, or placement for adoption within 31 days of the event will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

Special Enrollment for Medicaid and CHIP

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") requires that the Plan must permit you and your Dependent(s) to enroll (or disenroll) in the Plan following the occurrence of either of the following events:

- *Loss of coverage under Medicaid or a state child health plan*: If you or your Dependent(s) lose coverage under Medicaid or a state child health plan, you may request to enroll yourself and/or your Dependent(s) in the Plan not later than 60 days after the date coverage ends under Medicaid or the state child health plan.

- *Gaining eligibility for coverage under Medicaid or a state child health plan*: If you and/or your Dependent(s) become eligible for financial assistance (such as a premium subsidy) from Medicaid or a state child health plan, you may request to enroll yourself and/or your child(ren) under the Plan, provided that your request is made no later than 60 days after the date that Medicaid or the state child health plan determines that you and/ or your Dependent(s) are eligible for such financial assistance. If you and/or Dependent(s) are currently enrolled in the Plan, you have the option of terminating the enrollment of you and/or your child(ren) in the Plan and enroll in Medicaid or a state child health plan. Please note that, once you terminate your enrollment in the Plan, your children's enrollment will also be terminated.

Coverage will become effective as of the first day following the loss of coverage or the date of gain in eligibility.

Failure to notify the Company of your loss or gain of eligibility for coverage under Medicaid or a state children's health plan within 60 days will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

How to Make Changes to Your Elections

If you have a change in status, you may be eligible to make certain changes to your election that are consistent with this status change. For example, in the event you get married, you would be eligible to elect coverage for your new Spouse. To change your elections under the Plan, log on to Benefits US at www.eBenefitsUS.com or call Customer Service at 1-888-860-6178. When you log on to the Benefits US home page, click on the "Add Life Status Change Event" link to create your status change event and make your election changes.

IMPORTANT! You must notify Benefits US of a change in status event within 31 days of the event if you want to change your benefit elections. This rule does not apply to Special Enrollment for Medicaid and CHIP, for which you have 60 days from the date of the event to notify Benefits US of the loss or gain of coverage under Medicaid or a state child health plan. Otherwise, you must wait until the next annual enrollment period or another change in status event to make any changes to your elections under the Plan.

When Coverage Ends

In general, your Plan coverage will end for you and your Dependents:

- The end of the month in which your employment ends;
- When you stop making required contributions;
- When you or your Dependents are no longer eligible to participate in the Plan (for instance, due to a change in your employment status); or

- When the Plan is terminated.

You may be able to continue your Plan coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). (*See the "COBRA Continuation of Coverage" Section of this SPD for further details.*) You may also be able to continue coverage if you are on an approved Family and Medical Leave Act (FMLA) leave or are on military leave. (*See the "COBRA Continuation of Coverage" Section of this SPD for further details*.)

Resuming Participation

If You Are Rehired or If You Return from a Leave of Absence or Furlough

If your employment with the Company is terminated, or if you waived coverage during or when you started an approved leave of absence or a furlough, you will again become eligible to participate in the Plan on the date you are rehired, recalled or returned to work.

If you are rehired, recalled, or returned to work and resume participation in the Plan in a later Plan Year than the Plan year in which you terminated, took leave, or were furloughed, you must make new benefit elections for you and your eligible Dependents at the time you are rehired, recalled or returned to work by re-enrolling in the Plan.

If you are rehired, recalled, or returned to work during the same Plan Year in which you terminated, took leave, or were furloughed, your prior enrollment election will be reinstated for the balance of the Plan Year, although you can make changes within 31 days of the date of your rehire or return to work. For example, if your employment terminated during March and you were rehired in October, the benefit elections that were in place in March immediately prior to your termination would be reinstated in October.

If You Go To Work for Another Employer

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines the circumstances under which eligibility for medical coverage may be limited based on a pre-existing medical condition.

If you leave the Company and go to work for another employer whose medical plan includes a pre-existing condition exclusion from coverage, the HIPAA "prior creditable coverage" provisions may help exempt you from any such exclusion.

When you leave the Company, you and your covered Dependents will automatically receive a certificate of creditable coverage from the Company. This certificate will document that you (and any of your eligible, enrolled Dependents) had medical coverage under the Plan.

If your new employer's medical plan includes a pre-existing condition clause, you can use your certificate(s) of creditable coverage to shorten or eliminate any applicable waiting period for full medical benefits under the new employer's plan.

You can request a certificate of creditable coverage by calling the appropriate medical carrier.

Please note: A certificate of creditable coverage will not be effective to shorten or eliminate any applicable waiting period under a pre-existing condition clause of a new employer if there is a lapse of 63 days or more between the period of creditable coverage under this plan and your enrollment in your new employer's health plan.

SCHEDULE OF BENEFITS

The Health Options Plan – In Brief

The Plan is a high deductible health plan (HDHP) that is sponsored by the Company for which you and the Company share the cost. The Plan is designed to comply with specific requirements under federal law to make the Plan a "qualified" HDHP, allowing you to contribute to your own health savings account (HSA). Together, the Plan and HSA provide you and your family flexibility and control in choosing health care services and making decisions regarding how your health care dollars are spent.

The Plan is made available by the Company on a self-funded basis and helps to protect you and your family in case you have significant health care expenses. The Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) and is a qualified HDHP under the Internal Revenue Code, which means that, as a participant in the Plan, you are considered an HSA-eligible individual who is able contribute to your own HSA.

The Plan covers 100% of preventive care for nationally recommended services without cost sharing as long as you receive your preventive care from an In-Network Provider. For other expenses (including non-Network preventive care expenses), coverage is available after you met your Deductible. Once you have met your Deductible, the Plan will reimburse a percentage of the cost for Covered Services. You will be responsible for covering the remainder of the expense of Covered Services, up to an annual Out-of-Pocket Maximum. After the Out-of-Pocket Maximum amount has been met, the Plan will cover 100% of Covered Services for the remainder of the Plan Year as specified elsewhere in this SPD.

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

The Health Savings Account

An HSA is a tax-favored medical savings account available only to participants in a qualified HDHP.

The Company intends for any employee's HSA to be exempt from ERISA by complying with the terms of the Department of Labor Field Assistance Bulletin Nos. 2004-01 and 2006-02. An employee's HSA is not part of the Plan and is not established on behalf of an employee or maintained by the Company. Instead, an HSA is an account that you independently open through ACS/BNY Mellon Bank (i.e., the custodian) to which you can contribute pre-tax or after-tax dollars. As explained in "*Contributions to your HSA*" below, the Company will also contribute to an HSA that you open through ACS/BNY Mellon Bank if you are an active employee.

You can use the money in your HSA on a tax-free basis to pay for any qualified medical expenses, including your annual Deductible if you choose. Furthermore, unused dollars roll over from year to year and therefore can be saved and accumulate through retirement. If you use the money in your HSA to pay for any expenses that are not qualified medical expenses, the distribution is subject to income tax, and may be subject to a 20% penalty.

While all domestic employees of the Company are eligible to enroll in the Plan, certain individuals are not eligible to open a HSA. You are not eligible to open a HSA if you fall into any of the following categories:

- **You are enrolled in another medical plan (e.g., your Spouse's plan), unless it is a qualified high deductible health plan (enrollment in a non-high deductible dental or vision plan is permitted);**
- **You are enrolled in Medicare;**
- **You are eligible to be claimed as a dependent on another individual's tax return;**
- **You are not a U.S. resident, or are a resident of American Samoa;**
- **You are a veteran and have received veterans' benefits within the last three months; or**
- **You are an active member of the military.**

In addition, please note the following about HSAs:

- The Internal Revenue Service does not consider a domestic partner to be a spouse under federal tax law, regardless of state law exceptions. Therefore, you can't withdraw funds tax free to pay for your domestic partner's qualified expenses, unless he or she satisfies the definition of a qualified tax dependent under the Internal Revenue Code.
- In accordance with the requirements of the Patient Protection and Affordable Care Act (commonly known as Health Care Reform), you will be permitted to cover your child under the Plan through the end of the calendar year in which they attain age 26. However, distributions from your HSA for medical expenses incurred by your adult child may not be tax-fee in all circumstances. In order for such distributions to be tax-free, your adult child must satisfy the definition of dependent (either "qualifying child" or "qualifying relative") under the Internal Revenue Code. If you provide over half the support for your child for the calendar year, your child may meet the definition of qualifying relative. However, you should contact your tax advisor for further information regarding this definition and the tax consequences of using your HSA to pay for your child's medical expenses.
- You must remain enrolled in the Plan for 12 consecutive months or you cannot make a full-year contribution to the HSA. If you do make a full-year contribution to the HSA, a portion of the HSA contributions may be subject to tax and penalty.
- Most states consider HSA contributions and earnings to be non-taxable with the exception of Alabama, California and New Jersey, which do tax HSA contributions and earnings. New Hampshire and Tennessee do not tax contributions but do consider earnings on HSA funds to be taxable.

Contributions to your HSA

Your overall contribution limit is indexed for inflation each year by the Internal Revenue Service.

For 2012, contributions to your HSA are as described below:

Contributions to your HSA	Total Possible Employee Contributions	Company Contribution (Active Employees Only)	Overall Limit
Employee Only Coverage	$2,600	$500	$3,100
Employee + Spouse/Child(ren)/Family Coverage	$5,250	$1,000	$6,250

Note: The above "overall limit" applies to all combined contributions from any source, except rollover funds.

For 2013, contributions to your HSA are as described below:

Contributions to your HSA	Total Possible Employee Contributions	Company Contribution (Active Employees Only)	Overall Limit
Employee Only Coverage	$2,750	$500	$3,250
Employee + Spouse/Child(ren)/Family Coverage	$5,450	$1,000	$6,450

IMPORTANT INFORMATION ABOUT COMPANY CONTRIBUTIONS TO YOUR HSA:

- For any Plan Year in which you participate in the Plan, failure to open an HSA within 60 days after the later of (i) January 1st or (ii) the date of you become a participant in the Plan, will result in forfeiture of the Company contributions that would have been made to your HSA for that Plan Year.

- The Company will pro-rate its contributions based on the number of months you are enrolled in the Plan during the year. For example, if you join the Company in June and elect Employee Only coverage

effective 7/1, the Company will contribute ½ the total annual amount it contributes for active employees (i.e., for 2012 or 2013, $500 x 50% or $250.)

- The Company will only make contributions for active employees. No contributions will be made for you if you are not considered an active employee because you are retired, laid off/on furlough or on leave for disability.

- The Company reserves the right to change the level of Company contribution at any time.

Financial Tools

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

Choice of Providers

The Plan offers discounts through partnerships with Providers throughout the nation. You have automatic access to Provider directories, free of charge, by accessing the member site at www.anthem.com, or by contacting the Anthem Customer Service Department at the phone number listed on your Identification Card.

With the Plan, you have the flexibility to see any licensed health care provider you choose. The Doctors Plus Directory can help you locate a Provider near you. The level of your health coverage under the Plan depends on whether you use Providers who offer In-Network discounts or Providers who do not offer In-Network discounts.

Your health Plan is a Preferred Provider Organization (PPO). To receive maximum benefits at the lowest Out-of-Pocket expense under a PPO, Covered Services must be provided by an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use an Out-of-Network Provider, you are responsible for any balance due between the Out-of-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Deductibles, and non-covered charges. This means that your Out-of-Pocket expenses will be higher when you use Out-of-Network Providers.

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

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

BlueCard® PPO Program

Nationwide, Blue Cross and Blue Shield plans have established Preferred Provider Organization (PPO) networks of physicians, hospitals, and other healthcare providers. As a PPO Member, you have access to these networks through the BlueCard PPO Program. The suitcase logo on your I.D. card indicates that you are a Member of the BlueCard PPO Program. Visit www.anthem.com, and select the "PPO/EPO" network; or call the Customer Service number on your Identification Card to locate participating providers.

The BlueCard program helps reduce your costs when you access covered Out-of-Network care throughout the United States (to receive In-Network benefits, you must use a provider in the BlueCard PPO program). Simply show your Identification Card with the PPO in a suitcase logo, and you will benefit from discounts that these BlueCard providers have agreed to extend to their local Blue Cross and/or Blue Shield plan. Be sure to verify that the provider participates in the BlueCard Program. To do so, visit www.anthem.com and select the

"Traditional/Indemnity" network. Services rendered by these providers will be considered Out-of-Network, but will generally cost less than services provided by other Out-of-Network Providers.

BlueCard® Worldwide

The BlueCard Worldwide program provides coverage through an international network of hospitals, doctors and other healthcare providers if you need emergency services when traveling outside the United States. With this program, you will receive care from licensed healthcare professionals. The program also assures that at least one staff member at the Hospital will speak English, or the program will provide translation assistance. To find participating providers, visit **www.bcbs.com** and click on "Healthcare Anywhere." In order to access the international directory of providers, you will need to enter your Anthem identification number that is located on the front of your Identification Card.

Calendar Year Deductible

Before the Plan begins to pay benefits, you must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the table below.

Your Calendar Year Deductible Responsibility

Deductible	In-Network	Out-of-Network
Employee Only	$1,250	$2,500
Employee + Spouse	$2,500	$5,000
Employee + Child(ren)	$2,500	$5,000
Employee + Family	$2,500	$5,000

The In-Network and Out-of-Network amounts can be satisfied by a family member or a combination of family members.

Deductible amounts accumulate separately for In-Network and Out-of-Network.

Coinsurance: The Plan Pays/You Pay

Once you satisfy the Deductible under the Plan, the Plan pays the following percentage of Covered Services for In-Network benefits and the following percentage of Maximum Allowed Amount for Out-of-Network expenses:

Coinsurance Health Coverage	In-Network	Out-of-Network
The Plan Pays	80%	60%
Your Coinsurance Responsibility	20%	40%

Additional Protection:
For your protection, the total amount you spend for Out-of-Pocket is limited.

The Plan's Out-of-Pocket Maximum is the most that you will pay toward covered health expenses in a Plan Year. Once you reach the Out-of-Pocket Maximum under the Plan, the Plan pays 100% of Covered Services for Providers who offer discounts and 100% of Maximum Allowed Amount charges for Providers who do not offer discounts.

Note: The Out-of-Pocket Maximum includes all Deductibles and/or Coinsurance you incur in a Plan Year. The In-Network and Out-of-Network amounts can be satisfied by a family member or a combination of family members. Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the Plan Year.

Out-of-Pocket Maximum

Annual Out-of-Pocket Maximum	In-Network	Out-of-Network
Employee Only	$4,000	$8,000
Employee + Spouse	$8,000	$16,000
Employee + Child(ren)	$8,000	$16,000
Employee + Family	$8,000	$16,000

Plan Benefits	In-Network	Out-of-Network
Note: All dollar and visit limits are combined In-Network and Out-of-Network, unless otherwise noted. Any benefits with combined visit limits will count services on the same date of services as 1 visit, unless otherwise noted.		
Allergy Care (Testing and Treatment)	Deductible/80%	Deductible/60%
Behavioral Health / Substance Abuse Care **Inpatient Facility and Professional** • Pre-certification required • Detox is covered • Residential Treatment is not covered • Developmental delay is not covered **Outpatient Facility and Professional** • Includes intensive outpatient therapy (IOP) and partial hospitalization (PHP) • Treatment for ADD/ADHD • ABA Therapy not covered **Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.**	Deductible/80%	Deductible/60%
Dental / Oral Surgery / TMJ Services		
Dental • Accidental Injury to sound and natural teeth (limited to treatment completed within 12 months of the injury) • Dental implants needed as the result of an accident are covered to a max of $15,000 per lifetime. Treatment must begin within 12 months from date of accident.	Deductible/80%	Deductible/60%
TMJ Treatment • Covered for surgical and non-surgical medical treatment. • Appliances are not covered. • TMJ surgery requires precertification.	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Oral Surgery • Removal of impacted teeth not covered • Dental anesthesia covered if related to a payable oral surgery procedure.	Covered at surgical level	Covered at surgical level
Diagnostic Physician's Services – Non-routine Outpatient, Office or Independent Lab **Note:** Professional Pathology, Anesthesiology and Radiology (PAR) services rendered by non-participating professional providers are covered at the In-Network deductible and coinsurance. Diagnostic services are defined as any claim for services performed to diagnose an illness or injury. **Mammography and Colorectal/Sigmoidoscopy procedures**: The first procedure per calendar year will be covered in full regardless of diagnosis billed. The subsequent claim will process at the non-routine level for professional and facility.	Deductible/80%	Deductible/60%

Plan Benefits	In-Network	Out-of-Network
Emergency Care, Urgent Care, and Ambulance Services		
Emergency room use for a medical emergency • **Facility** • **Emergency Room Physician**	Deductible/80%	(See Note)
Non-emergency use of the emergency room • **Facility** • **Emergency Room Physician**	Deductible/80%	Deductible/60%
Urgent Care clinic visit	Deductible/80%	Deductible/60%
Ambulance services (Medically Necessary) Land/Air	Deductible/80%	(See Note)
Note: Care received Out-of-Network for a medical emergency will be provided at the In-Network level of benefits if the following conditions apply: A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm. Care may also be approved as an Authorized Service. **If an Out-of-Network Provider is used, however, you are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.**		
Home Health Care Services • Limited to a maximum of 120 days per calendar year combined In-Network and Out-of-Network • Home Infusion Therapy is covered and counts toward the visit maximum.	Deductible/80%	Deductible/60%
Hospice Care Services	Deductible/80%	Deductible/60%
Medical, social, psychological and spiritual care provided for the terminally ill in the appropriate setting using an interdisciplinary team of professionals. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.		
Hospital Inpatient Services – Pre-certification Required Accidental Injury / General Illness / Inpatient Surgery / Maternity and Newborn Care		
• **Room and board (Semiprivate or ICU/CCU)** • **Hospital services and supplies**	Deductible/80%	Deductible/60%
• **Physician Services:** ► **Surgeon:** Cosmetic/Reconstructive Surgery is subject to Medical Necessity ► ***Assistant Surgeon:** covered only if surgery is covered ► ***Anesthesiologist** ► ***Radiologist / *Pathologist / Other Diagnostic and X-ray and Lab Tests**	Deductible/80%	Deductible/60%

Plan Benefits	In-Network	Out-of-Network
Hospital Inpatient Services continued…		
• **Inpatient Physical Medicine Rehab** Limited to 60 days per calendar year combined In-Network and Out-of-Network	Deductible/80%	Deductible/60%
• **Inpatient Medical Care** ► General Medical Care / Consultations / Second Opinion / Intensive Care / Monitoring / Maternity ► Newborn Care (see note below) ► Bariatric surgery is covered	Deductible/80%	Deductible/60%
• **Inpatient Therapies** ► Chemotherapy / Radiation Therapy / Dialysis/ Hemodialysis / Infusion Therapy / Physical / Occupational / Speech / Respiratory	Deductible/80%	Deductible/60%
*Anesthesiologist, radiologist, pathologist and assistant surgeon charges are always paid at the In-Network level of benefits (Coinsurance) when providing inpatient services**.** **Note:** For well newborn, no separate deductible is applied, the deductible is applied to the mother's claim only.		
Maternity Care & Other Reproductive Services		
Maternity Care - Professional: • Includes Abortion (Therapeutic or Elective, surgical and non-surgical) • Dependent daughter maternity is covered. • Screening for gestational diabetes covered at 100% when performed in-network (Effective January 1, 2013)	Deductible/80%	Deductible/60%
Newborn Services – Professional: • * Well Newborn – Deductible does not apply	*Deductible/80%	*Deductible/60%
• **Note:** Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified		
Infertility Services • Covered for diagnosis and treatment of an underlying medical condition. • Non-covered services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed

Maternity Care & Other Reproductive Services continued...		
Sterilization Services • Vasectomy • Reversals are not covered • Sterilization services for women, including tubal ligation, will be covered at 100% when performed in-network (Effective January 1, 2013; prior to January 1, 2013, only tubal ligation is covered at the benefit level of the services billed).	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Medical Supplies and Equipment		
Durable Medical Equipment (DME) Purchase & Rental • Includes medical supplies • The cost associated with breast pump rental and supplies will be covered at 100% when obtained from an in-network provider. Benefit will be limited to one per year. (Effective January 1, 2013) • Diabetic supplies that may be obtained through the pharmacy, are not covered under Medical (Insulin, needles, test strips, etc…)	Deductible/80%	Deductible/60%
Prosthetic Appliances (external) / **Orthotics** • Includes initial pair of glasses or contact lenses after cataract surgery. • Wigs and Toupees are limited to $1000 per lifetime, combined In-Network and Out-of-Network • Includes Foot Orthotics, 1 per calendar year based on Medical Necessity. • Includes Cranial Bands.	Deductible/80%	Deductible/60%
Nutritional Counseling for Diabetics and Non-Diabetics • Limited to 6 per calendar year combined In-Network and Out-of-Network; Visits are combined with diabetic and non-diabetic counseling • Nutritional Counseling for obesity (screening and dietitian visit only) is covered under Preventive Services at 100% for In-Network providers.	Deductible/80%	Deductible/60%
Outpatient Hospital / Ambulatory Surgical Center Facility Services		
• **Outpatient Facility / Ambulatory Surgical Center**	Deductible/80%	Deductible/60%
• **Outpatient Physician** services (surgeon, assistant surgeon, anesthesiologist, radiologist, pathologist, etc.) (See Note) ► Bariatric surgery is covered	Deductible/80%	Deductible/60%
• **Consultations / Second Opinion**	Deductible/80%	Deductible/60%

Outpatient Hospital / Ambulatory Surgical Center **Facility Services continued...** • **Note:** Professional Pathology, Anesthesiology and Radiology (PAR) services and assistant surgeon services rendered by non-par professional providers are covered at the In-Network deductible and coinsurance.		
Physician Services (Home and Office Visits) **Home and office visits** Covered services include: • Consultations and Second Opinions • Non-routine hearing and vision examinations • Acupuncture – subject to medical policy • Blood processing and storage Non-covered services include: • Routine foot care • Hearing Aid services (Hardware – Hearing Aids)	Deductible/80%	Deductible/60%
Pre-surgical and Pre-admission Testing	Deductible/80%	Deductible/60%
Office Surgery • Bariatric surgery is covered	Deductible/80%	Deductible/60%
Prescription Injectables / Prescription Drugs Dispensed in the Physician's Office	Deductible/80%	Deductible/60%
Contraceptives • IUDs, injections for Depo-Provera, diaphragm fittings, and any other FDA approved birth control devices are covered. Covered for birth control as well as medical conditions.	Deductible/80% (Prior to January 1, 2013) No Deductible/ 100% (Effective January 1, 2013)	Covered at the benefit level of the services billed
Preventive Services	No Deductible 100%	Deductible/60%
Preventive Services are defined as any claim submitted with a "well" diagnosis. **Mammography and Colorectal/Sigmoidoscopy procedures**: The first procedure per calendar year will be covered in full regardless of diagnosis billed. Subsequent procedures will be subject to HCR and if procedure falls outside of HCR, the subsequent claim will process at the non-routine level for professional and facility.		
Skilled Nursing Facility • Limited to 90 days per calendar year combined In-Network and Out-of-Network	Deductible/80%	Deductible/60%

Therapy Services (Outpatient)		
Cardiac Rehab – Subject to Medical Policy	Deductible/80%	Deductible/60%
Chemotherapy	Deductible/80%	Deductible/60%
Dialysis/Hemodialysis	Deductible/80%	Deductible/60%
Radiation Therapy	Deductible/80%	Deductible/60%
Respiratory Therapy	Deductible/80%	Deductible/60%
Chiropractic Care • Limited to 12 manipulations per calendar year	Deductible/80%	Not Covered
Physical Therapy	Deductible/80%	Deductible/60%
Occupational Therapy	Deductible/80%	Deductible/60%
Speech Therapy • Developmental delays not covered	Deductible/80%	Deductible/60%
Note: **Physical Therapy:** Limited to 30 visits per calendar year (combined Institutional & Professional and In-Network & Out-of-Network). After 30 visits, subject to Medical Necessity up to a combined 60 visit maximum. **Occupational and Speech Therapy:** Limited to a combined 30 visit maximum per calendar year (combined Institutional & Professional and In-Network & Out-of-Network). After 30 visits, subject to Medical Necessity up to a combined 45 visit maximum.		
Transplants		
Bone Marrow Donor Search Fee: • Limited to a Lifetime maximum of $30,000	Deductible/80%	Not Covered
Institutional and Professional:	Deductible/80%	Not Covered
Travel and Lodging: Provided the transplant is at a Blue Distinction Center Transplant (BDCT) facility and the patient lives at least 75 miles from the BDCT facility, then Lodging is covered, but limited to $50 per day for single occupancy or $100 per day for double occupancy. Travel and Lodging shall not to exceed a maximum of $10,000 per transplant. Meals are not covered.	No Deductible/100% when a BDCT facility is used	Not Covered
All Other Covered Transplant Services:	Covered at the benefit level of the services billed	Not Covered

Plan Benefits	In-Network	Out-of-Network
Prescription Drugs		
Prescription Drug Deductible and Out-of-Pocket Maximum Note: Prescription Drug coverage is subject to the overall plan deductible and out-of-pocket maximum. If your medication is preventive in nature, the deductible may not apply. Please reference the Preventive Drug List section for additional information.		
Prescription Drugs – Retail Pharmacy, Specialty Retail Pharmacy, and Specialty Mail Service Drugs (30-day supply) **Please note that the Copayments below will not apply until after the Deductible has been met.**		
Tier 1 (Generic) – Copayment payable per prescription	$5	Not Allowed
Tier 2 (Brand Formulary) – Coinsurance payable per prescription	20% with $60 max	Not Allowed
Tier 3 (Brand Non-Formulary) – Coinsurance payable per prescription	50% with $100 max	Not Allowed
Mail Service Prescription Drugs –(90-day supply)		
Tier 1 (Generic) – Copayment payable per prescription	$10	Not Allowed
Tier 2 (Brand Formulary) – Coinsurance payable per prescription	20% with $120 max	Not Allowed
Tier 3 (Brand Non-Formulary) – Coinsurance payable per prescription	50% with $200 max	Not Allowed

Note: The available day supply may be less than the 34 or 90 days shown above due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Note: If you request a Brand Drug when a Generic Drug is available, you will be required to pay the difference in cost between the Brand and Generic Drug in addition to the Generic Copayment.

Mandatory Mail Service for Maintenance Drugs – If you are taking a Prescription Drug that is considered a Maintenance Medication, you may obtain up to two 34 day prescription renewals of the same Maintenance Medication at your local Retail Pharmacy. You must then begin using a Mail Service Pharmacy to purchase Maintenance Medications. If you are not sure whether the Prescription Drug you are taking is considered a Maintenance Medication, please contact Customer Service at the number on the back of your Identification Card for more information. Ordering Maintenance Medications through a Mail Service Pharmacy eliminates the need for monthly trips to the pharmacy.

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

Prescription Drugs continued...

Note: A limited number of Prescription Drugs require Prior Authorization for Medical Necessity. If Prior Authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires Prior Authorization, please call Customer Service. If seeking reimbursement for an In-Network Pharmacy claim, you or your Covered Dependent must file a claim for reimbursement; you or your Covered Dependent may be responsible for the difference between the negotiated rate and the Pharmacy's actual charge.

Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug benefits when obtained from an In-Network Pharmacy.

Note: If you are taking a maintenance medication that requires you to use the mail service pharmacy, you may also fill your prescription for up to 90 days at any CVS Pharmacy.

Over-the-Counter Medications: Certain prescribed over-the-counter ("OTC") medications will be covered when a retail network pharmacy is used. Covered OTC preventive medications are those required under the Patient Protection and Affordable Care Act. Coverage of OTC preventive medications may change as additional regulations are issued. You must have a prescription from your Physician in order for the covered OTC medication to be covered at 100%. For the most up-to-date list of preventive care OTC medications that are covered under the Patient Protection and Affordable Care Act, go to http;//www.healthcare.gov.

The Out-of-Area Program ("OOA")

If you live outside any PPO Plan network service area, medical coverage is available through the Out-of-Area Program. The Out-of-Area Program is a non-network program. With a non-network program, you may receive care from any provider you choose. After you pay an annual deductible, the Plan will begin to share the cost of care with you. Generally, the Plan pays a certain percentage of the reasonable and customary (R&C) charges for services and you pay the rest. R&C charges are based on the typical amounts charged by most providers in your geographic area for specific medical services. If the cost of your care is more than the R&C limit set by the Plan, you pay the amount that exceeds the limit in addition to any applicable deductible and coinsurance amounts.

When you reach the annual out-of-pocket maximum, the Plan will pay 100% of your eligible expenses for the rest of the Plan Year (excluding charges above the R&C limit or charges not otherwise covered by the Plan.)

OOA Calendar Year Deductible

Before the Out-of-Area Program begins to pay benefits, you must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the table below.

The deductible, co-insurance and out-of-pocket maximum are the same if In-Network or Out-of-Network providers are used. However, If an Out-of-Network Provider is used, you are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. *NOTE: This does not apply to anesthesiologist, radiologist, pathologist and assistant surgeon charges when receiving inpatient services*.

Your Calendar Year Deductible Responsibility

Deductible	OOA
Employee Only	$1,250
Employee + Spouse	$2,500
Employee + Child(ren)	$2,500
Employee + Family	$2,500

OOA Coinsurance: The Plan Pays/You Pay

Coinsurance Health Coverage	OOA
The Plan Pays	80%
Your Coinsurance Responsibility	20%

Additional Protection:
For your protection, the total amount you spend for Out-of-Pocket is limited.

The Plan's Out-of-Pocket Maximum is the most that you will pay toward covered health expenses in a Plan Year. Once you reach the Out-of-Pocket Maximum under the Plan, the Plan pays 100% of Covered Services for Providers who offer discounts and 100% of Maximum Allowed Amount charges for Providers who do not offer discounts.

Note: The Out-of-Pocket Maximum includes all Deductibles and/or Coinsurance you incur in a Plan Year. The amounts can be satisfied by a family member or a combination of family members. Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the Plan Year.

OOA Out-of-Pocket Maximum

Annual Out-of-Pocket Maximum	OOA
Employee Only	$4,000
Employee + Spouse	$8,000
Employee + Child(ren)	$8,000
Employee + Family	$8,000

Plan Benefits	OOA
Note: Any benefits with combined visit limits will count services on the same date of services as 1 visit, unless otherwise noted.	
Allergy Care (Testing and Treatment)	Deductible/80%
Behavioral Health / Substance Abuse Care **Inpatient Facility and Professional** • Pre-certification required • Detox is covered • Residential Treatment is not covered • Developmental delay is not covered **Outpatient Facility and Professional** • Includes intensive outpatient therapy (IOP) and partial hospitalization (PHP) • Treatment for ADD/ADHD • ABA Therapy is not covered **Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.**	Deductible/80%
Dental / Oral Surgery / TMJ Services	
Dental • Accidental Injury to sound and natural teeth (limited to treatment completed within 12 months of the injury) • Dental implants needed as the result of an accident are covered to a max of $15,000 per lifetime. Treatment must begin within 12 months from date of accident.	Deductible/80%
TMJ Treatment • Covered for surgical and non-surgical medical treatment. • Appliances are not covered. • TMJ surgery requires precertification.	Covered at the benefit level of the services billed
Oral Surgery • Removal of impacted teeth not covered • Dental anesthesia covered if related to a payable oral surgery procedure.	Covered at surgical level
Diagnostic Physician's Services – Non-routine Outpatient, Office or Independent Lab **Note:** Diagnostic services are defined as any claim for services performed to diagnose an illness or injury. **Mammography and Colorectal/Sigmoidoscopy procedures**: The first procedure per calendar year will be covered in full regardless of diagnosis billed. The subsequent claim will process at the non-routine level for professional and facility.	Deductible/80%

Emergency Care, Urgent Care, and Ambulance Services

Emergency room use for a medical emergency — Deductible/80%
- **Facility**
- **Emergency Room Physician**

Non-emergency use of the emergency room — Deductible/80%
- **Facility**
- **Emergency Room Physician**

Urgent Care clinic visit — Deductible/80%

Ambulance services (Medically Necessary) Land/Air — Deductible/80%

Home Health Care Services — Deductible/80%
- Limited to a maximum of 120 days per calendar year
- Home Infusion Therapy is covered and counts toward the visit maximum.

Hospice Care Services — Deductible/80%

Medical, social, psychological and spiritual care provided for the terminally ill in the appropriate setting using an interdisciplinary team of professionals. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Hospital Inpatient Services – Pre-certification Required
Accidental Injury / General Illness / Inpatient Surgery / Maternity and Newborn Care

- **Room and board (Semiprivate or ICU/CCU)** — Deductible/80%
- **Hospital services and supplies**

- **Physician Services:** — Deductible/80%
  - ► **Surgeon:** Cosmetic/Reconstructive Surgery is subject to Medical Necessity
  - ► ***Assistant Surgeon:** covered only if surgery is covered
  - ► **Anesthesiologist**
  - ► ***Radiologist / *Pathologist / Other Diagnostic and X-ray and Lab Tests**

- **Inpatient Physical Medicine Rehab** — Deductible/80%
  Limited to 60 days per calendar year

- **Inpatient Medical Care** — Deductible/80%
  - ► General Medical Care / Consultations / Second Opinion / Intensive Care / Monitoring / Maternity
  - ► Newborn Care (see note below)
  - ► Bariatric surgery is covered

Hospital Inpatient Services continued...

- **Inpatient Therapies** — Deductible/80%
  - ► Chemotherapy / Radiation Therapy / Dialysis/ Hemodialysis / Infusion Therapy / Physical / Occupational / Speech / Respiratory

Note: For well newborn, no separate deductible is applied, the deductible is applied to the mother's claim only.

Maternity Care & Other Reproductive Services

Maternity Care - Professional: — Deductible/80%

- Includes Abortion (Therapeutic or Elective, surgical and non-surgical)
- Dependent daughter maternity is covered.
- Screening for gestational diabetes covered at 100% (Effective January 1, 2013)

Newborn Services – Professional: — *Deductible/80%

- * Well Newborn – Deductible does not apply

- **Note:** Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified

Infertility Services — Covered at the benefit level of the services billed

- Covered for diagnosis and treatment of an underlying medical condition.
- Non-covered services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.

Sterilization Services — Covered at the benefit level of the services billed

- Vasectomy
- Reversals are not covered
- Sterilization services for women, including tubal ligation, will be covered at 100% (Effective January 1, 2013; prior to January 1, 2013, only tubal ligation is covered at the benefit level of the services billed.)

Medical Supplies and Equipment

Durable Medical Equipment (DME) Purchase & Rental — Deductible/80%

- Includes medical supplies

- The cost associated with breast pump rental and supplies will be covered at 100%. Benefit will be limited to one per year. (Effective January 1, 2013)

- Diabetic supplies that may be obtained through the pharmacy, are not covered under Medical (Insulin, needles, test strips, etc…)

Medical Supplies and Equipment continued...	
Prosthetic Appliances (external) / **Orthotics** • Includes initial pair of glasses or contact lenses after cataract surgery. • Wigs and Toupees are limited to $1,000 per lifetime • Includes Foot Orthotics, 1 per calendar year based on Medical Necessity. • Includes Cranial Bands.	Deductible/80%
Nutritional Counseling for Diabetics and Non-Diabetics • Limited to 6 per calendar year; Visits are combined with diabetic and non-diabetic counseling • Nutritional Counseling for obesity screening and dietitian visit only) is covered under Preventive Services at 100%.	Deductible/80%
Outpatient Hospital / Ambulatory Surgical Center Facility Services	
• **Outpatient Facility / Ambulatory Surgical Center**	Deductible/80%
• **Outpatient Physician** services (surgeon, assistant surgeon, anesthesiologist, radiologist, pathologist, etc.) ► Bariatric surgery is covered	Deductible/80%
• **Consultations / Second Opinion**	Deductible/80%
Physician Services (Home and Office Visits) **Home and office visits** Covered services include: • Consultations and Second Opinions • Non-routine hearing and vision examinations • Acupuncture – subject to medical policy • Blood processing and storage Non-covered services include: • Routine foot care • Hearing Aid services (Hardware – Hearing Aids)	Deductible/80%
Pre-surgical and Pre-admission Testing	Deductible/80%
Office Surgery • Bariatric surgery is covered	Deductible/80%
Prescription Injectables / Prescription Drugs Dispensed in the Physician's Office	Deductible/80%
Contraceptives • IUDs, injections for Depo-Provera, diaphragm fittings, and any other FDA approved birth control devices are covered. Covered for birth control as well as medical conditions. Prescription coverage is limited to generics and single source brands. Any OTC requires a prescription for coverage.	Deductible/80% (Prior to January 1, 2103) No Deductible/100% (Effective January 1, 2013)

Preventive Services	No Deductible/100%
Preventive Services are defined as any claim submitted with a "well" diagnosis. **Mammography and Colorectal/Sigmoidoscopy procedures**: The first procedure per calendar year will be covered in full regardless of diagnosis billed. The subsequent claim will process at the non-routine level for professional and facility.	
Skilled Nursing Facility • Limited to 90 days per calendar year	Deductible/80%
Therapy Services (Outpatient)	
Cardiac Rehab – Subject to Medical Policy	Deductible/80%
Chemotherapy	Deductible/80%
Dialysis/Hemodialysis	Deductible/80%
Radiation Therapy	Deductible/80%
Respiratory Therapy	Deductible/80%
Chiropractic Care • Limited to 12 manipulations per calendar year	Deductible/80%
Physical Therapy	Deductible/80%
Occupational Therapy	Deductible/80%
Speech Therapy • Developmental delays not covered	Deductible/80%
Note: **Physical Therapy:** Limited to 30 visits per calendar year (combined Institutional & Professional). After 30 visits, subject to Medical Necessity up to a combined 60 visit maximum. **Occupational and Speech Therapy:** Limited to a combined 30 visit maximum per calendar year (combined Institutional & Professional). After 30 visits, subject to Medical Necessity up to a combined 45 visit maximum.	
Transplants	
Bone Marrow Donor Search Fee: • Limited to a Lifetime maximum of $30,000	Deductible/80%
Institutional and Professional:	Deductible/80%
Travel and Lodging: Provided the transplant is at a Blue Distinction Center Transplant (BDCT) facility and the patient lives at least 75 miles from the BDCT facility, then Lodging is covered, but limited to $50 per day for single occupancy or $100 per day for double occupancy. Travel and Lodging shall not to exceed a maximum of $10,000 per transplant. Meals are not covered.	No Deductible/100% when a BDCT facility is used
All Other Covered Transplant Services:	Covered at the benefit level of the services billed

Plan Benefits	OOA
Prescription Drugs	
Prescription Drug Deductible and Out-of-Pocket Maximum Note: Prescription Drug coverage is subject to the overall plan deductible and out-of-pocket maximum. If your medication is preventive in nature, the deductible may not apply. Please reference the Preventive Drug List section for additional information.	
Prescription Drugs – Retail Pharmacy, Specialty Retail Pharmacy, and Specialty Mail Service Drugs (30-day supply) **Please note that the Copayments below will not apply until after the Deductible has been met.**	
Tier 1 (Generic) – Copayment payable per prescription	$5
Tier 2 (Brand Formulary) – Coinsurance payable per prescription	20% with $60 max
Tier 3 (Brand Non-Formulary) – Coinsurance payable per prescription	50% with $100 max
Mail Service Prescription Drugs –(90-day supply)	
Tier 1 (Generic) – Copayment payable per prescription	$10
Tier 2 (Brand Formulary) – Coinsurance payable per prescription	20% with $120 max
Tier 3 (Brand Non-Formulary) – Coinsurance payable per prescription	50% with $200 max

Note: The available day supply may be less than the 34 or 90 days shown above due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Note: If you request a Brand Drug when a Generic Drug is available, you will be required to pay the difference in cost between the Brand and Generic Drug in addition to the Generic Copayment.

Mandatory Mail Service for Maintenance Drugs – If you are taking a Prescription Drug that is considered a Maintenance Medication, you may obtain up to two 34 day prescription renewals of the same Maintenance Medication at your local Retail Pharmacy. You must then begin using a Mail Service Pharmacy to purchase Maintenance Medications. If you are not sure whether the Prescription Drug you are taking is considered a Maintenance Medication, please contact Customer Service at the number on the back of your Identification Card for more information. Ordering Maintenance Medications through a Mail Service Pharmacy eliminates the need for monthly trips to the pharmacy.

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

Prescription Drugs continued...

Note: A limited number of Prescription Drugs require Prior Authorization for Medical Necessity. If Prior Authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires Prior Authorization, please call Customer Service. If seeking reimbursement for an In-Network Pharmacy claim, you or your Covered Dependent must file a claim for reimbursement; you or your Covered Dependent may be responsible for the difference between the negotiated rate and the Pharmacy's actual charge.

Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug benefits when obtained from an In-Network Pharmacy.

Note: If you are taking a maintenance medication that requires you to use the mail service pharmacy, you may also fill your prescription for up to 90 days at any CVS Pharmacy.

Over-the-Counter Medications: Certain prescribed over-the-counter ("OTC") medications will be covered when a retail network pharmacy is used. Covered OTC preventive medications are those required under the Patient Protection and Affordable Care Act. Coverage of OTC preventive medications may change as additional regulations are issued. You must have a prescription from your Physician in order for the covered OTC medication to be covered at 100%. For the most up-to-date list of preventive care OTC medications that are covered under the Patient Protection and Affordable Care Act, go to http;//www.healthcare.gov.

SPECIAL MEDICAL PROGRAMS

ConditionCare

ConditionCare takes an individual-centered approach to supporting people living with chronic illnesses. Health professionals, including nurses, dietitians, pharmacists, exercise physiologists and others coach individuals to better understand their condition(s) and encourage self-management skills. Individualized goals are established to guide them through behavior change for a healthier lifestyle. Current programs include:

- Asthma
- Chronic heart failure (CHF)
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes.

24/7 NurseLine

Receive immediate assistance from a registered nurse, toll-free, 24-hours, 7-days-a-week. Simply call 800-700-9184. If you need advice on comforting a baby in the middle of the night or need to locate a doctor, Anthem will be there. Call Anthem to:

- Assess and understand your symptoms.
- Find additional help to make informed healthcare decisions.
- Locate a doctor, Hospital or other practitioner.
- Get information about an illness, medication or prescription.
- Find information about a personal health issue such as diet, exercise or high blood pressure.
- Answer questions on pregnancy.
- Get assistance with discharge from a Hospital.
- Help you decide if a medical situation requires emergency treatment.

You can also access an easy-to-use audio library. You'll hear advice and news delivered in English and Spanish on more than 330 topics — from colds and sore throats to diabetes and cancer.

24/7 NurseLine is not for emergencies, so please do not call if you believe you or a family member:

- Is having a heart attack or stroke
- Is severely injured
- Is unable to breathe
- May have ingested poisonous or toxic substances
- Is unconscious.

In these cases or for any other emergencies, call 911 or your local emergency service as soon as possible.

Here's how to use NurseLine:

- Dial **800-700-9184** and follow the prompts to speak with a nurse or listen to the audiotape messages.
- If you have additional questions after listening to a tape, **simply connect to the on-duty nurse.**

HEALTH CARE MANAGEMENT - PRECERTIFICATION

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

If you have any questions regarding the information contained in this section, you may call the Customer Service telephone number on 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 Claims Administrator within 2 business days after 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 Claims Administrator will review your Plan 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 Plan or is Experimental/Investigative as that term is defined in this Plan.

Post Service Clinical Claims 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 Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Precertification

Precertification is required for the services listed in this Section. Note that this list is not all inclusive and is subject to change; please call the Customer Service telephone number on your Identification Card to confirm the most current list and requirements under the Plan.

Inpatient Admission:

- All acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehabilitation, and Obstetrical delivery stays beyond the 48/96 hour Federal mandate length of stay minimum (including newborn stays beyond the mother's stay)
- Emergency Admissions (requires Plan notification no later than 2 business days after admission

Outpatient Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance (does not include 911 initiated emergency transport)
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bariatric surgery
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction, Mastectomy for Gynecomastia and other Breast Procedures

- Canaloplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Chiropractic Care - review after visit limit
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation
- Diagnostic Testing
    - Diagnosis of Sleep Disorders
    - Genetic Testing for Cancer Susceptibility
- DME/Prosthetics
    - Bone Growth Stimulator: Electrical or Ultrasound
    - Communication Assisting / Speech Generating Devices
    - Custom made and /or Custom fitted prefabricated orthotics and braces
    - External (Portable) Continuous Insulin Infusion Pump Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
    - Hospital Beds, Rocking Beds, and Air Beds
    - Microprocessor Controlled Lower Limb Prosthesis
    - Pneumatic Pressure Device with Calibrated Pressure
    - Power Wheeled Mobility Devices
    - Prosthetics: Electronic or externally powered and select other prosthetics
    - Standing Frame
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Home Infusion Therapy (billed by home infusion specialist)
- Implantable Cardioverter-Defibrillator (ICD)
- Implantable Infusion Pumps for Cancer Treatment
- Implanted Devices for Spinal Stenosis
- Implanted Spinal Cord Stimulators
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar spinal surgeries
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
- Nasal/Sinus Surgery for the Treatment of Obstructive Sleep Apnea (OSA) (Including Radiofrequency Ablation of Nasal Turbinates for Nasal Obstruction with or without OSA), Surgical Treatment of Migraine Headaches: Septoplasty
- Occiptal nerve stimulation
- Orthognathic Surgery
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Percutaneous Neurolysis for Chronic Back Pain
- Photocoagulation of Macular Drusen
- Physician Attendance and Supervision of Hyperbaric Oxygen Therapy
- Plastic/Reconstructive surgeries:

    - Abdominoplasty, Panniculectomy, Diastasis Recti Repair
    - Blepharoplasty
    - Brachioplasty
    - Buttock/Thigh Lift
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Insertion/Injection of Prosthetic Material Collagen Implants
    - Liposuction/Lipectomy
    - Procedures Performed on Male or Female Genitalia
    - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
    - Procedures Performed on the Trunk and Groin
    - Repair of Pectus Excavatum / Carinatum
    - Rhinoplasty
    - Skin-Related Procedures
- Private Duty Nursing (home)
- Percutaneous Spinal Procedures
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Radiation therapy
    - Intensity Modulated Radiation Therapy (IMRT)
    - Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Thoracoscopy, surgical
- Tonsillectomy in Children
- Therapy: PT/OT/ST – suspend for medical review after visit limits
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment.
- Wearable Cardioverter Defibrillators

Human Organ and Bone Marrow/Stem Cell Transplants

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

Mental Health/Substance Abuse (MHSA):
Pre-certification Required

- Acute Inpatient Admissions
- Electric Convulsive Therapy (ECT)
- Employer Group Specific
    - Intensive Outpatient Therapy (IOP)
    - Partial Hospitalization (PHP)

Referrals:

Requests for Out-of-Network Referrals for care that the Claims Administrator determines are Medically Necessary may be pre-authorized, based on network adequacy.

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

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

Claims may be denied if required medical necessity documentation is not provided to the Claims Administrator.

The Claims 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. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically. The Plan document takes 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 Customer Service telephone number on 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 you or your Covered Dependent's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of you or your Covered Dependent or the ability of you or your Covered Dependent to regain maximum function or subject you or your Covered Dependent to severe pain that cannot be adequately managed without such care or treatment.
- **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.
- **Retrospective -** A request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is 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 in general on federal regulations. You may call the telephone number on your Identification Card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other 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	72 hours from the receipt of the request
Concurrent Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make a decision, the Claims 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 Claims 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 Claims Administrator's possession.

The Claims Administrator will provide notification of its decision in accordance with 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 you or your Covered Dependent or authorized 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. The service or surgery must be a covered benefit under your Plan;
3. The service cannot be subject to an exclusion under your Plan, including but not limited to a Pre-Existing Condition limitation or exclusion; and
4. You must not have exceeded any applicable limits under your Plan.

Care Management

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

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 those Plan participants 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 you or your Covered Dependent and/or designated representative, treating Physician(s), and other Providers. The licensed health care professional remains in contact with you or your Covered Dependent 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 you or your Covered Dependent's needs. Care coordination may include referrals to external agencies and available community-based programs and services.

BENEFITS

The following medical services are Covered Services under the Plan, except as otherwise indicated. All Covered Services must be Medically Necessary, whether provided through In-Network Providers or Out-of-Network Providers. Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details.

Ambulance Service
Local service to the closest appropriate Hospital in connection with care for a Medical Emergency or if otherwise Medically Necessary. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance is covered subject to Medical Necessity.

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

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

Hospital Inpatient Care
Benefits for Inpatient Hospital and Physician charges are Covered Services.

Professional Outpatient Care
Covered Services include:

- Professional care in the Outpatient department of a Hospital;
- Physician's office visits; and
- Services within the lawful scope of practice of a licensed, approved provider.

Note: To be reimbursable, care must be given by a psychiatrist, psychologist, neuropsychologist, or a mid-level provider such as a licensed clinical social worker, mental health clinical nurse specialist, a marriage and family therapist, or a licensed professional counselor.

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

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

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

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

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

Dental Services
Related to Accidental Injury
Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting you or your Covered Dependent'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. Treatment must be completed within 12 months of the injury date.

Diabetes
Equipment and Outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Effective January 1, 2013, screenings for gestational diabetes are covered under “Preventive Care.”

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

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

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

Effective January 1, 2013, contraceptive devices, implants, and injectables are covered under “Preventive Care.”

Emergency Services
Life-threatening Medical Emergency or Serious Accidental Injury.

Coverage is provided for Hospital emergency room care including 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 Medical 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. Emergency Service care does not require any prior authorization from the Plan.

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

The Maximum Allowed Amount for emergency care from a Non-Network Provider will be:

- The amount negotiated with In-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.

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

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

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

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

Home Health Care Services
Home Health Care provides a program for you or your Covered Dependent's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by you or your Covered Dependent's attending Physician. Services may be performed by either In-Network or Out-of-Network Providers.

Some special conditions apply:
- The Physician’s statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce Outpatient benefits available under the Physical Therapy section shown in this Plan.
- You or your Covered Dependent must be essentially confined at home.

Covered Services:
- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to you or your Covered Dependent. Private duty nursing care is covered. Home Infusion therapy is covered.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable you or your Covered Dependent to understand the emotional, social, and environmental factors resulting from or affecting you or your Covered Dependent's illness.

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

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

Hospice Care Services
Hospice benefits cover Inpatient and Outpatient services for patients certified by a Physician as terminally ill with a life expectancy of six months or less.

Your Plan provides Covered Services for Inpatient and Outpatient Hospice care as stated in the **Schedule of Benefits**. The Hospice treatment program must:
- Be recognized as an approved Hospice program by the Claims Administrator;
- Include support services to help covered family members deal with you or your Covered Dependent's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
  - Provides an organized system of home care;
  - Uses a Hospice team; and
  - Has around-the-clock care available.

To qualify for Hospice care, the attending Physician must certify that you or your Covered Dependent is not expected to live more than six months. Also, the Physician must design and recommend a Hospice Care Program.

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

Network

Inpatient Services
- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent Semiprivate rate. If you are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

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

Length of Stay
- Determined by Medical Necessity.

Out-of-Network

Hospital Benefits
If you are confined in an Out-of-Network Hospital, your benefits will be significantly reduced, as explained in the **"Schedule of Benefits"** section.

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

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

Human Organ and Tissue Transplant Services
Notification
The Plan strongly encourages you or your Covered Dependent to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the customer service telephone number on your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist you or your Covered Dependent in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or SPD exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you or your Covered Dependent.

Covered Transplant Benefit Period
Starts one day prior to a Covered Transplant Procedure and continues for 364 days. If, within this time frame, a second Covered Transplant Procedure occurs, the covered transplant benefit period will begin one day prior to the second Covered Transplant Procedure and continue for 364 days.

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

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

Maternity Care & Infertility Services

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

Maternity benefits are provided for a female employee or female Spouse or female domestic partner of the employee only. Dependent daughter maternity is covered.

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

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

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

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

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

Medical Care
General diagnostic care and treatment of illness or Injury. Some procedures require pre-certification.

Non-Contracted Freestanding Ambulatory Facility
Any services rendered or supplies provided while you are a patient or receiving services at or from a Non-Contracted Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

Out-of-Network Hospital Benefits
If you are confined in an Out-of-Network Hospital, your benefits will be significantly reduced, as explained in the **"Schedule of Benefits"** section.

Nutritional Counseling for Diabetes
Nutritional counseling related to the medical management of diabetes as stated in the Schedule of Benefits.

Obesity
Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan. Pre-certification is required, and coverage is only provided for gastric bypass, vertically banded gastroplasty and adjustable gastric banding procedure (lap band).

Oral Surgery
Covered Services include only the following:

- Fracture of facial bones;
- Removal of impacted teeth;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while you or your Covered Dependent is covered by this Plan and performed within 180 days after the accident.

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

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

Outpatient CT Scans and MRIs
These services are covered at regular Plan benefits.

Outpatient Surgery
In-Network Hospital Outpatient department or In-Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. These benefits are subject to both Deductible and percentage payable (Coinsurance) requirements. Benefits for treatment by an Out-of-Network Hospital are explained under "Hospital Services".

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

Physician Services
You may receive treatment from an In-Network or Out-of-network Physician. However, payment is significantly reduced if services are received from an Out-of-network Physician. Such services are subject to your Deductible and Out-of-Pocket requirements.

Preventive Care
Preventive Care services include Outpatient services, Office Services, and, effective January 1, 2013, Contraceptives. 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.

Individuals 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 or Coinsurance from you or your Covered Dependent when provided by an In-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. Effective January 1, 2013, additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

    Examples of preventive care for women include:
    a. Contraceptive methods, sterilization procedures, and patient education and counseling.
    b. Well Woman visits to obtain recommended preventive services, including preconception and prenatal care.
    c. Screening for gestational diabetes, human papillomavirus; human immune-deficiency virus; and interpersonal and domestic violence.
    d. Counseling for sexually transmitted diseases.
    e. Breastfeeding support, supplies, and counseling.

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; http://www.ahrq.gov/clinic/uspstfix.htm; or http://www.cdc.gov/vaccines/recs/acip/.)

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

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

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

Reconstructive Surgery
Pre-certification is required. Reconstructive surgery does not include any service otherwise excluded in this SPD. (See "Limitations and Exclusions.")

Reconstructive surgery is covered only to the extent Medically Necessary. This includes the correction of significant anatomic deformities which are not within normal anatomic variation and which are caused by illness or Injury for the purpose of improving the significant anatomic deformity toward a normal appearance; or

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

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

Skilled Convalescent Care during a period of recovery is characterized by:
- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at you or your Covered Dependent's residence.

Covered Services include:
- Semiprivate or ward room charges including general nursing service, meals, and special diets. If you or your Covered Dependent stays in a private room, this Plan pays the Semiprivate room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient; or
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

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

Benefits will not be provided when:
- You or your Covered Dependent reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- You or your Covered Dependent is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Surgical Care
Surgical procedures including the usual pre- and post-operative care. Some procedures require pre-certification.

Treatment of Accidental Injury in a Physician's Office
All Outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under you or your Covered Dependent's Physician's office benefit and are subject to Deductible and Coinsurance requirements.
Prescription Drugs

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

PHARMACY BENEFITS

The pharmacy benefits available to you under this Plan are managed by CVS Caremark, the Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company that manages your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating the covered Prescription Drug list (also known as a Formulary) establishing a network of retail pharmacies and operating a Mail Service pharmacy. The PBM also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Customer Service telephone number on your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Claims Administrator can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Plan or utilization guidelines. Please also refer to the Schedule of Benefits for details about Pharmacy Benefits.

Prior Authorization
Prior Authorization may be required in order for some prescription drugs to be covered. As part of your benefit, CVS Caremark will conduct an evaluation to determine if the drug's prescribed use meets the defined clinical criteria. Through this process, your doctor and CVS Caremark pharmacists will work together to ensure the drug you are prescribed is the most appropriate for your condition. To initiate a Prior Authorization evaluation, doctors must call CVS Caremark at 1-800-626-3046. This call will determine whether the drug will be covered under the prescription benefit. For any requests that are denied, the CVS Caremark Appeals Program information is provided to the caller.

Drug Limitations
Drug Limitations refer to the amount of drug received over a defined time period. These allowances are intended to ensure proper prescription utilization by allowing you to receive drugs in clinically appropriate quantities. The classes and limitations are routinely reviewed by pharmacists and doctors to ensure clinical appropriateness.

Step Therapy
Under your plan, you may have to follow certain steps in order to have coverage for medications in some drug classes. For example, your plan may require that you use a generic medication first before a brand name drug will be covered. If you have questions about the drug classes associated with this program please contact customer care at 1-866-760-4276

Preventive Drug List
CVS Caremark takes many steps to help you and your Covered Dependents save money and better manage your overall health. One of the many ways we do this is by using a Preventive Drug List.
The Preventive Drug List offers you savings on prescriptions that you take regularly to prevent certain health conditions. This cost saving program allows the medication in the specified drug classes to bypass your deductible. With the deductible bypassed, you are only responsible to pay a copay for your medications even if your annual plan deductible has not yet been met. If you have any questions regarding the Preventive Drug List or the drug classes associated with it please contact Customer Care at

1-866-760-4276. You can also access the Preventive Drug List by registering and logging into your CVS Caremark account at www.caremark.com.

Specialty Management
In addition to Prior Authorization, US Airways participates in CVS Caremark Specialty Management program to help manage Biotech/Specialty injectable and oral medicines. Under the Specialty Guideline Management program, an approval will be required for select medicines. There will be a review of clinical information from your doctor for approval of treatment with these medicines. Decisions are based on guidelines specific for the drug and are administered by a CVS Caremark clinical specialist. If you are prescribed a non-preferred specialty medication, CVS Caremark will work closely with your prescriber to target a preferred therapy instead.

Specialty Pharmacy Network
The PBM's Specialty Pharmacy Network is required if you or your Covered Dependents use Specialty Drugs.

"Specialty Drugs" are Prescription Legend Drugs which:

- Treat complex chronic and/or rare diseases;
- Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

You may obtain the list of Network Specialty Pharmacies and covered Specialty Drugs by calling the Customer Service telephone number on your Identification Card or review the lists on The Claims Administrator's website at www.caremark.com.

Deductible/Copayment/Coinsurance
Each Prescription Order may be subject to Deductible and Copayment/Coinsurance. If the Prescription Order includes more than one covered Drug, a separate Copayment will apply to each covered Drug. Please see the Schedule of Benefits for any applicable Coinsurance. If you receive Covered Services from an Out-of-Network Pharmacy you will have no coverage for the prescription or service received.

Days Supply
The number of days supply of a Drug, which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits.

Formulary
The Plan follows a drug Formulary in determining payment and Covered Services. You will be responsible for an additional Copayment amount depending on whether a Formulary or non-Formulary drug is obtained. Please see the Schedule of Benefits.

Tiers
Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug has been classified by the Plan as a first, second, or third "tier" Drug. The determination of tiers is made by the Plan is based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

Payment of Benefits
The amount of benefits paid is based upon whether you receive the Covered Services from an In-Network Pharmacy, an Out-of-Network Pharmacy, or the PBM's Mail Service Program. It is also based upon which Tier, the Claims Administrator, has classified the Prescription Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The Claims Administrator retains the right at the Claims Administrator's discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Copayment/Coinsurance for which you are responsible.

Your Copayment(s)/Coinsurance amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by an In-Network Pharmacy or through the PBM's Mail Service, you are responsible for all Copayment/Coinsurance amounts.

For Covered Services provided by an Out-of-Network Pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a In-Network or an Out-of-Network Pharmacy.

In-Network Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at an In-Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable [Copayment/]Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to the Plan with a written request for refund.

Specialty Drugs - you or your Physician can order your Specialty Drugs directly from a Specialty Network Pharmacy, simply call the Customer Service telephone number on the back of your ID card. If you or your Physician orders your Specialty Drugs from a Specialty Network Pharmacy, you will be assigned a patient care coordinator who will work with you and your Physician to obtain Authorization and to coordinate the shipping of your Specialty Drugs directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your Specialty Drug Prescription.

Out-of-Network Pharmacy – Out of Network Pharmacy claims are not covered.

The Mail Service Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the PBM's Mail Service. Your Physician may also phone in the prescription to the PBM's Mail Service Pharmacy. You will need to submit the applicable Coinsurance and/or Copayment amounts to the PBM's Mail Service when you request a prescription or refill.

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

LIMITATIONS AND EXCLUSIONS

The Plan excludes coverage for certain services. Please contact the Claims Administrator if you have questions regarding what services are excluded. The following medical services are excluded and NOT covered under the Plan:

ACT OF WAR/MILITARY DUTY
Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities as required by law.

CUSTODIAL/CONVALESCENT CARE
Custodial care, defined as care essentially designed to assist individuals to meet their activities of daily living, such as but not limited to services which constitute personal care (including; help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not entail or require continuous attention of trained medical personnel).

Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.

DENTAL SERVICES
Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered. Exceptions to this exclusion include dental treatment and oral surgery related to the mouth up to a year after an accident: Dental services required as the result of an accident, may be covered under the medical program subject to certain medical necessity limitations and could include treatment for standard reconstruction (plates and crowns). Services are also limited to the replacement of sound and natural teeth. Only when deemed a medically necessary covered health service and the only alternative to restore the tooth/teeth/arch to it’s functional condition, implants may be a covered expense (to a $15,000 lifetime maximum).

ELIGIBILITY
Charges for treatment received before coverage under this option began or after it is terminated.

EXPERIMENTAL/INVESTIGATIONAL
Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are in our judgment, Experimental or Investigational for the diagnosis being treated.

Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.

FOOT CARE
Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for impaired circulation to the lower extremities.

Shoe inserts, orthotics (will be covered if prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary).Services and supplies related to routine foot care; except for procedures associated with diabetic treatment and when needed

for severe systemic disease. Routine foot care services that are not covered include: cutting or removal of corns and calluses; nail trimming or cutting; and debriding (removal of dead skin or underlying tissue). Hygienic and preventative maintenance including cleaning and soaking feet, applying skin creams in order to maintain skin tone and any other service not performed to treat a localized illness, injury or symptom involving the foot. Treatment of flat feet, treatment of subluxation (joint or bone dislocation) of the foot, shoes (standard or custom), lifts, wedges, and shoe orthotics that are not prescribed by a Physician.

GOVERNMENT AGENCY/LAWS/PLANS
Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if you or your Covered Dependent had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

Services paid under Medicare or which would have been paid if you or your Covered Dependent had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not you or your Covered Dependent has enrolled Medicare Part B.

Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.

MEDICATIONS
Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this Plan. Although coverage for Outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office. NOTE: While not covered under the Plan, information for coverage of prescription drugs can be obtained by contacting the pharmacy vendor: CVS Caremark.

Prescription drugs purchased at a doctor's office, skilled nursing facility, hospital or any other place that is not a pharmacy licensed to dispense drugs in the state where it is operated, self-injectable medications, non-injectable medications given in a physician's office except as required in an Emergency; and over the counter drugs and treatments.

MEDICALLY NECESSARY
Care, supplies, or equipment not Medically Necessary, as determined by us, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

Vitamins, minerals and food supplement, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary. Coverage of food supplements is restricted to sole source nutrients which are not available over the counter or without a prescription.

Services for Hospital confinement primarily for diagnostic studies.

Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury or to correct a congenital defect.

MISCELLANEOUS
Donor Search/Compatibility Fee (except as otherwise indicated on the Plan Design).

Hearing aids, hearing devices or examinations for prescribing or fitting them.

Contraceptive drugs or services that are not described as "covered" above. NOTE: Information for coverage of prescription drugs can be obtained by contacting your pharmacy vendor: CVS Caremark.

Infertility treatment, services and associated expenses for artificial insemination including In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor semen and related costs including collection and preparation. NOTE: Diagnostic testing to determine the cause of infertility and prescription medication to treat infertility is covered under the Plan.

Hair transplants, hair pieces or wigs, wig maintenance, or prescriptions or medications related to hair growth.

Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided under “Covered Services”.

Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

Christian Science Practitioner.

Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products that are not described as "covered," above, or that exceed the coverage limits described above. NOTE: Information for coverage of prescription drugs related to smoking cessation can be obtained by contacting the pharmacy vendor: CVS Caremark.

Services provided in a Residential Treatment Center (RTC).

Services provided in a Halfway House.

Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of you or a Covered Dependent for which, in the absence of any health benefits coverage, no charge would be made; services provided to you or your Covered Dependent by a local, state, or federal government agency, or by a public school system or school district, except when the Plan’s benefits must be provided by law; services if you or your Covered Dependent is not required to pay for them or they are provided to you or your Covered Dependent for free.

SPECIAL CHARGES/SERVICES
Services or supplies provided by a member of your family or household.

Charges or any portion of a charge in excess of the maximum allowable amount as determined by the Claims Administrator.

Fees or charges made by an individual, agency or facility operating beyond the scope of its license.

Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.

Services for any form of telecommunication.

Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; 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 provider their test results; specific medical reports including those not directly related to treatment, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.

Private duty services provided by sitters or companions. Private duty services by Registered Nurses or Licensed Practical Nurses will also be excluded unless the services are part of an approved home health care or hospice program.

Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.

SURGERY
Charges for or related to sex change surgery or to any treatment of gender identity disorders.

Any service or supply rendered to a covered person for the diagnosis or treatment to improve or restore sexual function.

Reversal of vasectomy or tubal ligation.

Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.

THERAPIES
Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy, and boot camp therapy.

Applied Behavioral Analysis (ABA) Therapy is not covered.

VISION CARE
Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.

Vision Surgeries - Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or

astigmatism or any other correction of vision due to a refractive problem. Eye exercise therapy other than as a treatment for strabismus (misalignment of the eyes).

WEIGHT REDUCTION PROGRAMS
Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

CLAIMS PAYMENT

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the BlueCard® PPO Network Hospitals, Physicians and Ancillary Providers are used, claims for their services will generally not have to be filed by you or your Covered Dependent. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by contacting Benefits US Customer Service at 1-888-860-6178 or visiting www.anthem.com.

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

How to File Claims
Under normal conditions, the Claims Administrator should receive the proper claim form within 18 months after the service was provided. This Section of the SPD describes when to file a benefits claim and when a Hospital or Physician will file the claim for you.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, you must receive treatment from an In-Network Provider. When admitted to an In-Network Hospital, present your Identification Card. Upon discharge, you will be billed only for those charges not covered by the Plan.

When you receive Covered Services from an In-Network Physician or other In-Network licensed health care provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the provider.

For health care expenses other than those billed by an In-Network Provider, use a claim form to report your expenses. You may obtain these from the Company or the Claims Administrator. Claims should include your name, Plan and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for your records. The address is on the claim form. Contact information for the Claims Administrator also can be found at the end of this SPD.

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

When you fill a prescription at a retail or mail-order pharmacy, the pharmacy may automatically provide these prescription drugs, so you do not have to file a separate claim. However, you may be asked to pay the full cost or some portion of the prescription. If you disagree with this amount, you may submit a claim to the Plan for reimbursement in accordance with the claims filing procedures described in the SPD. When you have filed a claim with the Plan, your claim will be treated under the same procedures for post-service group health plan claims, as described below.

Maximum Allowed Amount
General
This Section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-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 the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

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

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

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

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this/your Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-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 In-Network Provider or visit www.anthem.com.

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

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

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the

following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this/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 Claims Administrator and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower Out of Pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or visit the Claims 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 an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your Out of Pocket responsibility. Although 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.

Your 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 an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this SPD 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 an In-Network or an Out-of-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 In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services
In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a Covered Service so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Services Performed During Same Session

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

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

Timeliness of Filing-Your Submitted Claims
To receive benefits, a properly completed claim form with any necessary reports and records must be filed by you within 18 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, you will be notified of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid. The Section below entitled "Initial Claims Determinations" includes more specific information about when the Claims Administrator will notify you about whether your claim will be covered under the Plan.

Necessary Information
In order to process your claim, the Claims Administrator may need information from the provider of the service. As individuals who are covered under the Plan, you and your Covered Dependents agree to authorize the Physician, Hospital, or other provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

Explanation of Benefits

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

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

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem's service area, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare Providers. Anthem's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access covered healthcare services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

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

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

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

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.

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

Assignment

You authorize the Claims Administrator, on behalf of the Company, to make payments directly to Providers for Covered Services. The Claims Administrator also reserves the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Claims Administrator will discharge the Company'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 the Employee Retirement Income Security Act of 1974 (ERISA) or any applicable Federal law.

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

The coverage and any benefits under the Plan are not assignable by any person without the written consent of the Plan, except as provided above.

Questions About Coverage or Claims
If you have questions about your coverage, contact your Plan Administrator or the Claims Administrator's Customer Service Department. Be sure to always give your Member Identification number.

When asking about a claim, give the following information:
- Identification number;
- Patient's name and address;
- Date of service and type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a In-Network Provider, call them directly or call the Claims Administrator.

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

An oral explanation of your benefits by an employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of your new address.

INITIAL CLAIMS DETERMINATION

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the Plan. The procedures and timeframes that apply will depend on the type of claims involved.

- An urgent claim is any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.
- A pre-service claim is a claim for benefits under the Plan for which you have not received the benefit and for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service or for which you are not required to obtain approval in advance.
- A concurrent care claim is a claim that arises when there is a reduction or termination of ongoing care.

For information about claims involving eligibility for coverage under the Plan in general, please contact Benefits US.

Timeframes for Determinations

If your claim is determined to be an urgent claim, a notice will be sent as soon as possible taking into account the medical exigencies, and in no case later than 72 hours after receipt of the claim. You may receive notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.

If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim. If the plan administrator determines that an extension is necessary due to matters beyond control of the plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The plan then will make its determination within 15 days from the date the plan receives your information, or, if earlier, the deadline to submit your information.

When you submit a post-service claim and your claim is denied, a notice will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. If the plan administrator determines that an extension is necessary due to matters beyond control of the plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The plan then will make its determination within 15 days from the date the plan receives your information, or, if earlier, the deadline to submit your information.

For concurrent care claims, you will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated, unless such a reduction or termination is due to a plan amendment or termination of the plan.

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

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

The procedure the Claims Administrator will satisfy follows the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

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

- Information sufficient to identify the claim involved
- The specific reason(s) for the denial;
- A reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- A description of any additional material or information needed to perfect your claim;
- An explanation of why the additional material or information is needed;
- A description of the Plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under the Employee Retirement Income Security Act of 1974 (ERISA) if you appeal and the claim denial is upheld;
- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- Information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you; and
- Information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- The Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- The Claims Administrator may notify you or your authorized representative within 48 hours orally and within 72 hours furnish a written notification.

YOUR RIGHT TO APPEAL

Appeals
Except for urgent claims, you will be entitled to two levels of appeal of any initial claims denial. For urgent claims, you will be entitled to one level of appeal under an expedited timeframe. You must file your first level of appeal 180 days from the date that your initial denial notice is received. If the denial is upheld on the first level of appeal, you will have 30 calendar days to file a second request for appeal. For non-urgent claims, you are required to complete a second level of appeal before submitting a request for external Review or a claim in court.

You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

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

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

All other requests for appeals should be submitted in writing by you or your Covered Dependent or an *authorized representative*, except where the acceptance of oral *appeals* is otherwise required by the nature of the *appeal* (e.g. urgent care). You or your authorized representative must submit a request for review to:

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

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:
- Was relied on in making the benefit determination; or
- Was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- Is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

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

For Out-of-State Appeals you have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How your Appeal will be Decided
When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon any determinations made at prior levels of review. The review will be conducted by an appropriate reviewer who did not make the determination during a prior level of review and who does not work for the person who made a determination during a prior level of review.
If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal
If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal. Only one level of appeal is available for urgent care claims. After this determination, you may be able to request external review or file a civil action under the Employee Retirement Income Security Act of 1974 (ERISA).

If you appeal any other pre-service claim, for both the first and second levels of appeal of a pre-service claim, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 15 days from the date your request is received.

If you appeal a post-service claim, for both the first and second levels of appeal of a post-service claim, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 30 days from the date your request is received.

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

Notice of Adverse Benefit Determination
If your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- Information sufficient to identify the claim involved
- The specific reason(s) for the denial;
- A reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- A description of any additional material or information needed to perfect your claim;
- An explanation of why the additional material or information is needed;
- A description of the Plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under the Employee Retirement Income Security Act of 1974 (ERISA) if you appeal and the claim denial is upheld;
- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- Information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A Description of any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you; and

- Information regarding your potential right to an External Appeal pursuant to federal law.

EXTERNAL REVIEW
If the outcome of the mandatory first and second level appeals (as applicable) is adverse to you, you may be eligible for an independent External Review pursuant to federal law when the adverse determination or final adverse determination involves a rescission of coverage or an issue of medical judgment. Medical judgment includes a decision based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a decision that a treatment is experimental or investigational. Contact the Claims Administrator if you have questions about whether your claims may be eligible for External Review.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. you or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your Identification Card and provide at least the following information:

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

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

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

This is an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or the Employee Retirement Income Security Act of 1974 (ERISA). When filing a request for external review, you will be required to authorize the release of any medical records that may be reviewed for the purpose of reaching a decision on the internal review.

Requirement to file an Appeal before filing a lawsuit
No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision during the internal Appeals Procedure on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure before filing a lawsuit or taking

other legal action of any kind against the Plan. If your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the SPD, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the SPD, Plan has the meaning listed in the **Definitions** Section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. An In-Network Provider can bill you for any remaining Coinsurance and Deductible under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for (*carve-out)* Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the Health Options Plan providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of a contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles and Coinsurance, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and In-Network Provider arrangements.
6. The amount that is subject to the Primary high-deductible health plan’s Deductible, if the Claims Administrator has been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code.
7. Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are: The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and

insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

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

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - The Plan covering the Custodial parent;
     - The Plan covering the spouse of the Custodial parent;
     - The Plan covering the non-custodial parent; and then
     - The Plan covering the spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If you are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering you as an employee, member,

subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as an employee or as a retired employee and is covered under his or her own Plan as an employee, member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree).

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6 - If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN
Maintenance/Hard Non-Duplication Option:
When you or your Covered Dependent is covered under two or more Plans which together pay more than this Plan's benefits, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable by this Plan will be reduced by the combined benefits of all other Plans covering you or your Dependent.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is secondary, the combined benefits of this Plan and the other Plan will never exceed what would have been provided by this Plan if primary. No benefits will be provided by this Plan when the amount paid by the other Plan is equal to or greater than the amount this Plan would have paid if Primary.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:
1. The Plan has paid or for whom the Plan have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for you or your Covered Dependent.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary
To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:
- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older; and
- Individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare
If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge you if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

SUBROGATION AND REIMBURSEMENT

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably requests to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's or its agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

    Your failure to cooperate with us is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with us. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery we might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all individuals and entities administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL INFORMATION

Protected Health Information Under HIPAA

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information (the "Privacy Rule"). The private health information protected under the Privacy Rule includes any individually identifiable health information maintained or transmitted by the Plan in any form or medium. Individually identifiable health information is health information that identifies you or creates a reasonable basis to believe it could be used to identify you, including information relating to your health condition or receipt of health care. This Plan, and US Airways as the Plan sponsor, will not use or disclose information that is protected under the Privacy Rule except as necessary for treatment, payment, health care operations, and Plan administration, or as permitted by law. In particular, the Plan will not, without authorization, use or disclose private health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Company. Under the Privacy Rule, all of the benefit administrators providing medical services under the Plan must also protect your private health information.

Under the Privacy Rule, you have certain rights with respect to your private health information, including certain rights to inspect and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices. A copy of the notice is available to you, upon request, from the Benefits US Customer Service by calling 1-888-860-6178. As the Claims Administrator of the 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 your Identification Card.

Worker's Compensation

The benefits under the Plan are not designed to duplicate any benefit for which you are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to you or a Covered Dependent shall be reimbursed by, or on behalf of, you or a Covered Dependent 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 or equivalent employer liability or indemnification law.

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 you or your Covered Dependents 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 you or your Covered Dependents shall be paid by or on behalf of you or your Covered Dependents to the Plan.

Medicare Program

Please refer to the SPD Section entitled "*The Health Savings Account*" in the Schedule of Benefits for important information regarding eligibility to contribute to an HSA if you are enrolled in Medicare.

When you are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payor, the benefits described in this SPD will be reduced by the amount of benefits allowed under Medicare for the same Covered Services. This reduction will be made whether or not you actually receive the benefits from Medicare. For the purposes of the calculation of benefits, if you or your Covered Dependent has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

- **If you Are Under Age 65 With End Stage Renal Disease (ESRD)**
  If you are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This includes the Medicare "three month waiting period" and the additional 30 months after the Medicare effective date. After 33 months, the benefits described in this Benefit Description will be reduced by the amount that Medicare allows for the same *Covered Services*.
- **If you Are Under Age 65 With Other Disability**
  If you are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This is the case only if you are actively employed by the Company or are the Covered Dependent of an actively employed Plan participant. If you take a medical leave of absence, retain coverage under the Plan, and start receiving disability benefits from the Company, the Plan will continue to pay primary for the first 6 months of your disability coverage, i.e., while disability benefits are subject to FICA tax. After this 6 month period, Medicare will become primary.
- **If you Are Age 65 or Older**
  If you are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Description before Medicare. This can be the case only if you are actively employed by the Company or are the Covered Dependent of an actively employed Plan participant.
- **Leave of Absence**
  If you take a leave of absence and retain coverage under the Plan, the Plan will continue to pay primary for as long as you retain your right to return to active employment, i.e., your employment is not terminated by the Company. If your employment is terminated by the Company, Medicare will become primary.

Right of Recovery

The Plan's right of recovery described in this SPD is contingent on such recovery being permissible under applicable federal law.

The Plan will have the right to recover payment from you or, if applicable, the Provider if such payment is made in error. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such recovery activity.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. The Claims Administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Claims Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator may not provide you with notice of overpayments made by the Plan or you if the recovery method makes providing such notice administratively burdensome.

Modifications or Changes in Coverage

The Plan Sponsor may change the benefits described in this SPD and you will be informed of such changes as required by law. The Plan shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Company, or by mutual agreement between the Claims Administrator and the Company without the consent or concurrence of any participant.

By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all participants legally capable of contracting, and the legal representatives of all participants incapable of contracting, agree to all terms, conditions, and provisions hereof.

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to participants, 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 Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Waiver

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

Company's Sole Discretion

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

Care Received Outside the United States

You will receive Plan benefits for care and treatment received outside the United States. Plan provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with your claim. All services will be subject to appropriateness of care. The Plan will reimburse you directly. Payment will be based on the Maximum Allowed Amount. Assignments of benefits to foreign providers or facilities cannot be honored.

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

WHEN COVERAGE TERMINATES

Rescission in Event of Fraud

Any act, practice, or omission by a Plan participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the Plan and the Plan may rescind coverage as a result. Any such fraudulent statements, including on Plan enrollment forms and in electronic submissions, will invalidate any payment or claims for services and will be grounds for rescinding coverage.

Termination of Coverage

Coverage under the Plan for you and your Covered Dependents may be continued as long as you are employed by the Company and meet eligibility requirements. It ceases if your employment ends, if you no longer meet eligibility requirementsor if the Plan ceases.

Coverage will also terminate if you fail to make any required contribution toward the cost of coverage for you and/or your Covered Dependents. In such a case, coverage will end at the expiration of the period covered by your last contribution.

Coverage of an enrolled child ceases at the end of the calendar year in which the child attains the age limit shown in the Eligibility Section. Coverage of a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Coverage of your Spouse terminates at the end of the month as of the date of divorce or death. Coverage of your domestic partner terminates at the end of the month he/she ceases to satisfy the criteria necessary to be considered a domestic partner.

Should you or any Covered Dependents be receiving covered care in the Hospital at the time your membership terminates for reasons other than the Company's cancellation of this Plan, or failure to pay the required Premiums, benefits for Hospital Inpatient care will be provided only to the extent available for that Hospital stay.

Certification of Prior Creditable Coverage

If your coverage under this Plan is terminated, you and your Covered Dependents will receive a certification that shows your period of coverage under this health benefit plan. You may need to furnish the certification if you become eligible under 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. You and your Dependents may request a certification within 24 months of losing coverage under this health benefit plan.

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 your Identification Card.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

You may be able to continue your medical coverage under this Plan under certain conditions.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) you, your Spouse (or domestic partner) and Dependent children may elect to temporarily continue medical coverage under this Plan in certain instances where coverage otherwise would be reduced or terminated. Individuals entitled to COBRA continuation (qualified beneficiaries) are you, your Spouse (or domestic partner) and your

Dependent children who are covered at the time of a qualifying event. In addition, a child who is born to you or adopted by or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary. Also, any child covered pursuant to a QMCSO is a qualified beneficiary. The table below provides a summary of the COBRA provisions outlined in this Section of the SPD.

Qualifying Events that Result in Loss of Coverage	**Maximum Continuation Period**		
	Employee	**Spouse**	**Child**
Employee's work hours are reduced and results in loss of coverage	18 months	18 months	18 months
Employee terminates employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee or Dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of the COBRA continuation period that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 Months	36 Months
Employee and Spouse legally divorce	N/A	36 Months	36 Months
Employee and Domestic Partner Terminate Partnership	N/A	36 Months	36 Months
Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours	N/A	36 Months*	36 Months
Child no longer qualifies as a Dependent	N/A	N/A	36 months

* 36-month period is counted from the date of eligibility for Medicare benefits.

Qualifying Events

As summarized in the preceding table, the following are examples of "qualifying events:"

- Termination;
- Reduction in hours;
- Disability;
- Death of employee;
- Divorce;
- Termination of Domestic Partnership; and
- Loss of dependency status.

If any of the above events occur, you may be entitled to continue your benefits under the Plan with COBRA.

If your employment terminates for any reason other than gross misconduct, or if your hours worked are reduced so that your Plan coverage terminates, you, your covered Spouse (or domestic partner) and Dependent children may continue health coverage under the Plan for up to 18 months.

If you (the employee) should die, become divorced or become entitled to Medicare, your covered Dependents whose health coverage under the Plan would be reduced or terminated may continue health coverage under the Plan for up to 36 months. Also, your covered children may continue health coverage for up to 36 months after they no longer qualify as covered Dependents under the terms of the Plan.

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked:

- If you, your Spouse (or domestic partner), or your Dependent(s) experience a second qualifying event within the original 18-month period that was due to termination of employment or reduction in hours, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event). (start here)

- If you (the employee) become entitled to Medicare (even if it was not a qualifying event for your covered Dependents because their coverage was not lost or reduced) and then a second qualifying event due to either your termination of employment or reduction in hours of work happens within 18 months, your Dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.

- If you or your Dependent is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA continuation coverage, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months) if the original qualifying event was termination or reduction in hours. To qualify for this disability extension, the Plan Administrator must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the Plan Administrator within 30 days after this determination.

Important Note

If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary who is a Spouse or Dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation coverage upon your divorce or loss of your child's Dependent status under the Plan, you or one of your Dependents must notify the Plan Administrator of your divorce or loss of Dependent status within 31 days of the later of the date of the event or the date the individual would lose coverage under the Plan. Your covered Dependents will then be provided with instructions for continuing their health coverage. Individuals already on COBRA continuation must notify the Plan Administrator within the same time frame if a divorce or loss of a child's Dependent status occurs that would extend the period of COBRA coverage for your Spouse (or domestic partner) or Dependent child(ren).

For other qualifying events (if your employment ends, your hours are reduced or you become entitled to Medicare), you and your covered Dependents will be provided with instructions for continuing your health

coverage under the Plan. In the event of your death, the Company will contact your covered Dependents to inform them how to continue health coverage under the Plan.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered Dependents must elect to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered Dependents(s) lose coverage as a result of the qualifying event; or

- The date the Plan notifies you and/or your covered Dependents of your right to elect to continue coverage as a result of the qualifying event.

Premium Due Date

If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation coverage, but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your COBRA continuation coverage will be terminated retroactively to the last day for which timely payment was made.

Cost of COBRA Continuation of Coverage

Continuing Coverage

The cost of COBRA continuation of coverage, including any extended period for disability is 102% of the full cost of Plan coverage.

Coverage During the Continuation Period

If coverage under the Plan is changed for active employees during the COBRA continuation period, the change also applies to individuals on COBRA continuation coverage. Qualified beneficiaries also may change their coverage elections under COBRA continuation coverage during the annual enrollment periods, if a change in status occurs, or at other times under the Plan to the same extent that similarly situated employees not receiving COBRA continuation coverage may do.

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any person will end when any of the following first occurs:

- The applicable COBRA continuation period ends;

- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due;

- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare (This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA coverage if bankruptcy is the qualifying event);

- The qualified beneficiary becomes covered under another group health plan with no exclusion or limitation for any pre-existing condition;

- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months;

- In the case of newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, COBRA continuation coverage ends for them on the date your COBRA continuation period ends unless a second qualifying event has occurred; or

- Group health coverage for all employees is terminated.

When your COBRA continuation coverage terminates, you may be able to convert to individual coverage under the Plan's conversion rights feature. Contact your COBRA administrator for more information about your conversion rights.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, eligible employees are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted due to military service, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

You may continue your medical coverage for a period of time by paying premiums as stated per Company policy or your collectively bargained agreement.

If you choose not to continue your medical coverage while on military leave, you are entitled to reinstated coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled work day following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days;

- Return to or reapply for reemployment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days; or

- Return to or reapply for reemployment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Continuation of Coverage While on a Family and Medical Leave

Under the Family and Medical Leave Act (FMLA), eligible employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time. If you take this unpaid leave and wish to continue your medical coverage under the Plan, you will be billed directly on a monthly basis, at the same rates applicable before the unpaid leave began.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care;

- To care for a Spouse, child, or parent who has a serious health condition; or

- For your own serious health condition.

The number of weeks of unpaid leave available to you for family and medical reasons may vary based on the applicable state law requirements.

DEFINITIONS

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

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

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

Behavioral Health Care
Includes services for Mental Health Disorders, and Substance Abuse.

Mental Health Disorders
Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Substance Abuse or Chemical Dependency
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. Substance Abuse services include:

Substance Abuse Rehabilitation Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individual treatment plans;

Substance Abuse Services within a General Hospital Facility (a general Hospital facility that provides services, on an Inpatient, 24-hour basis, for medical Detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or other drugs.

Benefit Period
One year, January 1 – December 31 (also called year or the calendar year). It does not begin before you or your Covered Dependent's Effective Date. It does not continue after you or your Covered Dependent's coverage ends.

Brand Name Drug
The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number

of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (Generic).

Centers of Excellence (COE) Network

A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein you or your Covered Dependents access select types of benefits through a specific network of medical centers.

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

Claims Administrator

The entities the Plan Sponsor chooses to administer certain aspects of the Plan. Anthem Insurance Companies, Inc. was chosen to administer medical, mental health and chemical dependency claims, and CVS Caremark was chosen to administer prescription drug claims, for this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Company

US Airways, Inc. (US Airways)

Coinsurance

If you or your Covered Dependent's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which you or your Covered Dependent is responsible is the Coinsurance amount. The Coinsurance is capped by the Out-of-Pocket Maximum.

Complications of Pregnancy

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

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

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

Congenital Anomaly

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

Coordination of Benefits

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

Copayment
A cost-sharing arrangement in which you or your Covered Dependents pay a specified charge for a Covered Service, such as the Copayment indicated in the **Schedule of Benefits** for a generic medication. You or your Covered Dependents are usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the provider when services are rendered.

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

Covered Dependent
Your child(ren), Spouse or domestic partner, or domestic partner's children who meet all the requirements of the Eligibility Section of this SPD and who you have enrolled in the Plan.

Covered Services
Medically Necessary health care services and supplies that are (a) defined as Covered Services in the Plan, (b) not excluded under such Plan, (c) not Experimental or Investigational and (d) provided in accordance with such Plan.

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

Creditable Coverage
Coverage under another health benefit plan is medical expense coverage with no greater than a 63 day gap in coverage under any of the following: (a) Medicare or Medicaid; (b) an employer-based accident and sickness insurance or health benefit arrangement; (c) an individual accident and sickness insurance policy; (d) a Spouse's benefits or coverage under Medicare or Medicaid or an employer-based health insurance benefit arrangement; (e) a conversion policy; or (f) similar coverage.

The Claims Administrator will issue a certificate of Creditable Coverage upon request or when you or your Covered Dependent leaves the Plan. Call the Customer Service number on your Identification Card to request such a certificate.

Custodial Care
Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that you or your Covered Dependent has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to your or your Covered Dependent's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by you or your Covered Dependent, general maintenance care of colostomy or ileostomy, routine services to

maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

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

Dependent
Dependents eligible for coverage under the Plan include your Spouse or domestic partner (as that term in defined in the "*Domestic Partners*" Section of the SPD). Dependents eligible for coverage under the Plan also include all children, including those of a domestic partner, who have not yet reached the age limit stated in the "*Eligibility*" Section of the SPD. Children include biological children, legally adopted children, children placed for adoption, and stepchildren. Also included are your children (or children of your Spouse or domestic partner) for whom you have legal responsibility resulting from a valid court decree.

The unmarried children of you or your domestic partner age 26 and over who are not self-supporting because of a permanent physical or mental disability and who are dependent upon you, as defined by the Internal Revenue Code for income tax purposes, remain covered under the Plan no matter what age, provided that the children remain disabled and that such children were physically or mentally disabled *and* covered by the Plan on the day before attaining age 26. Proof of incapacity may be required annually by the Plan, and you may be required to give the Claims Administrator evidence of your child's incapacity within 31 days of the child attaining age 26.

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

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

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

Effective Date
The date on which the Plan approves an individual for coverage. For an individual who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves such individual according to its normal procedures.

Elective Surgical Procedure
A surgical procedure that is not considered to be an emergency, and may be delayed by you or your Covered Dependent to a later point in time.

Emergency Medical Condition

("Emergency services," "emergency care," or "Medical Emergency") Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Experimental or Investigational

Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence.

Medical and scientific evidence means:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikcus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;
- The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
- Meets the following five technology assessment criteria:
    - The technology must have final approval from the appropriate government regulatory bodies.
    - The scientific evidence must permit conclusions concerning the effect of the technology of health outcomes.
    - The technology must improve the net health outcome.
    - The technology must be as beneficial as any established alternative.
    - The technology must be beneficial in practice.

Formulary

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

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

Generic Drugs
Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicate those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

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

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

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

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

Hospital
An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:
- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or disabled children.

Identification Card
The latest card given to you showing your identification and group numbers, the type of coverage you have and the date coverage became effective.

In-Network Provider
A physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to you or your Covered Dependents through negotiated reimbursement arrangements.

Ineligible Charges
Charges for health care services that are not Covered Services because the services are not Medically Necessary or pre-certification was not obtained. Such charges are not eligible for payment.

Ineligible Provider
A provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to you or your Covered Dependent by such a provider are not eligible for payment.

Infertile or Infertility
The condition of a presumably healthy participant who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Injury
Bodily harm from a non-occupational accident.

Inpatient
Treatment as a registered bed patient in a Hospital and for whom a room and board charge is made.

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

Mail Service
A prescription drug program which offers a convenient means of obtaining maintenance medications by mail if you or your Covered Dependent takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Pharmacy Mail Service, which has entered into a reimbursement agreement with the Claims Administrator and sent directly to you or your Covered Dependent's home.

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

Maximum Allowed Amount
The maximum amount that the Plan will allow for Covered Services you receive. For more information, see the "Claims Payment" Section.

Medical Facility
A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this SPD. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Claims Administrator.

Medical Necessity or Medically Necessary

The Plan reserves the right to determine whether a service or supply is Medically Necessary. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary. The Plan considers a service Medically Necessary if it is:

- Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- Compatible with the standards of acceptable medical practice in the United States;
- Not provided solely for your convenience or the convenience of the Physician, health care provider or Hospital;
- Not primarily Custodial Care; and
- Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an Outpatient basis.

Non-Covered Services

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

Out-of-Network Provider

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

Benefit payments and other provisions of this Plan are limited when a participant uses the services of Out-of-Network Providers.

Out-of-Pocket Maximum

The maximum amount of a your or your Covered Dependent's Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

Pharmacy

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

Physical Therapy

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

Physician

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

Plan

The Health Options Plan, which is an employee welfare benefit plan (as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA)), established by the Company effective as of January 1, 2012.

Plan Administrator
The Company is the Plan Administrator. In its role as Plan Administrator, US Airways maintains sole responsibility for the Plan and the benefits it provides. The Plan Administrator has the sole discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, including entitlement to benefits. The Plan Administrator also has the sole discretion to determine all matters relating to interpretation and operation of the Plan and may contract with third parties to provide some or all of these services to participants.

Plan Sponsor
The Company is the Plan Sponsor. A Plan Sponsor is the legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination.

Prescription Drug
A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Plan.

Prescription Drug Deductible
The amount of covered expenses you must pay each year before your Plan will make payments. The individual Deductible applies separately to each covered person.

Prescription Order, or Prescription
A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

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

QMCSO – Qualified Medical Child Support Order
A QMCSO creates or recognizes the right of a child who is covered by the QMCSO to be enrolled in, and to receive benefits under, a group health plan for which the employee is eligible; and includes the name and last known address of the employee and such child, a reasonable description of the type of coverage to be provided, and the period for which coverage must be provided.

Retail Health Clinic
A facility that provides limited basic medical care services to you or your Covered Dependents 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.

Semiprivate Room
A Hospital room which contains two or more beds.

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

Skilled Nursing Facility
An institution operated alone or with a Hospital which gives care after a you or your Covered Dependents leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by the Claims Administrator to meet the reasonable standards applied by any of the aforesaid authorities.

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

Spouse
For the purpose of this Plan, a Spouse is defined as a person who is married, as evidence by a valid marriage certificate, to a person of the opposite sex from that of the enrolling employee.

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

Transplant Providers
In-Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as an In-Network Transplant Provider by a designee of the Claims Administrator. 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 an In-Network Transplant Provider with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as an In-Network Transplant Provider by a designee of the Claims Administrator.

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

Utilization Review
A function performed by the Claims Administrator or by an organization or entity selected by the Claims Administrator to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, Outpatient care or diagnostic services are appropriate.

PLAN ADMINISTRATION

This information about the administration of the Plan is provided in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). While you should not need these details on a regular basis, the information may be useful if you have specific questions about your Plan.

Plan Sponsor

The name, address and telephone number of the Plan sponsor are:

US Airways, Inc.
4000 E. Sky Harbor Blvd.
Phoenix, AZ 85034
480-693-0800

The Health Options Plan is a group health plan providing medical benefits, including prescription drug, mental health and chemical dependency benefits.

Plan Administrator

The name, address and telephone number of the Plan Administrator are:

US Airways, Inc.
4000 E. Sky Harbor Blvd.
Phoenix, AZ 85034
480-693-0800

The Plan Administrator (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the Plan described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations of the Plan Administrator (or its delegate(s)) made pursuant to the Plan described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The Plan Administrator may delegate this discretionary authority to selected service providers.

Agent for Service of Legal Process

The name, address and telephone number of the agent for service of legal process:

US Airways, Inc.
Legal Department
4000 E. Sky Harbor Blvd.
Phoenix, AZ 85034
480-693-0800

Legal process also can be served on the Plan Administrator.

Identification Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to US Airways is 53-0218143. The plan number for the Plan is 514.

Plan Year

The Plan Year for purposes of the Plan's fiscal records is January 1 through December 31.

Organizations Providing Administrative Services under the Plan

Listed below are the names, addresses, phone numbers, and web site addresses of the organizations that provide administrative services under the Plan. These services include administering claims, administering appeals, and providing participant assistance.

Type of Benefits	**Claims Administrator and Claims Fiduciary**
Medical, Mental Health and Chemical Dependency	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 All appeals should be directed to: Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348
Prescription Drugs	CVS Caremark, Inc. ATTN: Client Services/US Airways, Inc. PO Box 52196 Phoenix, AZ 85072-2196 1-866-760-4276 www.caremark.com All appeals should be directed to: CVS Caremark, Inc. Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172 Additional Contract Information: Complementary blood glucose meters: 1-800-588-4456 CVS Caremark internet help desk (web support): 1-877-460-7766
HSA	ACS/BNY Mellon Bank For questions, contact: HSA Solution Contact Center 877-472-4200 https://hsamember.com/

Plan Funding

The Plan is a self-funded plan. Benefits are paid from employee contributions, as applicable, and from the general assets of US Airways.

Plan Document

This SPD is intended to help you understand the main features of the Plan. It should not be considered a substitute for the Plan document, which governs the operation of the Plan. That document sets forth all of the details and provisions concerning the Plan and is subject to amendment; the official Plan document may consist of one or more documents designated as Plan documents by the Company. If any questions arise that are not covered in this SPD or if this SPD appears to conflict with the official Plan document, the text of the official Plan document will govern.

Future of the Plan

The Company reserves the right, in its sole discretion, to change, modify amend or terminate the Plan, in whole or in part, to the extent it deems advisable, at any time for any reason. Such changes, modifications, amendments or termination will be undertaken by action of the Company's Board of Directors or an authorized officer, or as otherwise required by the Plan document. Furthermore, the Company reserves the right, in its sole discretion, to change any third party providing services to the Plan, including the Claims Administrator. Upon termination, any amounts payable under the terms of the Plan as in effect immediately before the termination will be paid in accordance with Plan terms. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.

The benefits under this Plan do not vest. The Company reserves the right, in its sole discretion, to determine the nature and amount of benefits, if any, that will be provided to individuals (and their Dependents) under the Plan, as well as the right to reduce, terminate or modify the terms or the amount of such benefits.

Limitation on Assignment

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to your creditors or anyone else. However, you may assign your right to benefits to the health provider who rendered the services under the Plan.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

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

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

Statement of Rights Under the Newborns' and Mother's Health Protection Act
Group Health Plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., your physician, nurse midwife, or physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

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

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

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

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

If you would like more information on WHCRA benefits, call your Plan Administrator.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")
If you or your Spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Company or Plan Administrator to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Special Enrollment Notice
If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, 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.

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

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

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

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

To request special enrollment or obtain more information, call the Customer Service telephone number on your ID Card, or contact your Plan Administrator.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report nine months after the end of the plan year or two months after the SAR is due (if an extension has been granted by the IRS).

Continue Group Health Plan Coverage

- Continue group health coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuers when you lose coverage under a group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 18 months after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court.

If it should happen that the plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.