PLAN DOCUMENT

FOR

COUNTY OF HENRICO
HEALTH PLAN

As Restated Effective Date January 1, 2015

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SECTION 1
INTRODUCTION

1.1 ESTABLISHMENT OF PLAN

The County of Henrico (hereinafter referred to as the "County") established the County of Henrico Health Plan (the "Plan"), effective January 1, 2008. The County established the Plan for the exclusive benefit of the Employees, Dependents, and eligible Retirees of the County of Henrico, Virginia, the County School Board of Henrico County, Virginia, and the Economic Development Authority of Henrico County, Virginia to provide health care benefits to such individuals. This Plan is amended and restated effective January 1, 2015.

1.2 PLAN DOCUMENT

This document shall constitute the written Plan Document for this Plan. It provides a description of the County of Henrico Health Plan. This document, its attachments and any amendments, the Plan ID card, enrollment change form, the Administrative Services Agreement and its amendments and its addenda constitute the entire agreement between the Participants and the Plan. No oral interpretations or statements of any person shall modify or otherwise affect the benefits, limitations, and exclusions of this Plan, convey or void any coverage, increase or reduce benefits under this Plan, or be used in the support or defense of a claim under this Plan.

The Plan described herein is designed to help covered individuals meet the cost of health care by providing benefits for hospital care, medical/surgical services, behavioral health services, prescription drug and vision services. The Effective Date of coverage for each Participant's current benefits is indicated on the Participant's Plan ID card.

This document describes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Defined Terms. Defines those Plan terms that have a specific meaning within the Plan Document.

General Information about the Plan.

General Provisions including Eligibility, Enrollment, Effective Date, and Termination. Explains eligibility for coverage under the Plan and when the coverage takes effect and terminates.

Participant Rights and Responsibilities. Outlines basic Participant rights and responsibilities with regard to receiving benefits under the Plan.

How the Health Plan Works. Explains the methods used to curb unnecessary and excessive charges.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Medical Benefits. Explains when the benefit applies and the types of charges covered.

Prescription Drug Benefits. Explains when the benefit applies and the types of charges covered.

Vision Benefits. Explains the benefits available and the types of charges covered.

Plan Exclusions. Shows what charges are **not** covered.

Claims and Payments. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Explains the Plan payment order when a person is covered under more than one plan.

Protected Health Information. Explains the roles of the Plan and the Plan Sponsor with regard to protecting the privacy of protected health information.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Qualified Medical Child Support Order Procedures. Explains the rights under the legislation and the Plan's and the Participants' responsibilities to ensure the order is correctly followed.

Newborns' and Mothers' Health Protection Act. Provides an overview of the requirements under the Newborns' and Mothers' Health Protection Act of 1996.

Women's Health and Cancer Rights Act of 1998. Provides an overview of the requirements under the Women's Health and Cancer Rights Act of 1998.

Miscellaneous. Provides miscellaneous provisions related to general operation of the Plan.

SECTION 2
DEFINED TERMS

The following terms have special meanings and when used in this Plan Document will be capitalized.

Activities of Daily Living
means walking, eating, drinking, dressing, toileting, transferring (*e.g*., wheelchair to bed), and bathing.

Adverse Benefit Determination
is any denial, reduction of a benefit, or failure to provide a benefit, in whole or in part, by the health plan.

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

Child
means a biological child, stepchild, adopted child or child placed for adoption, an eligible foster child, or other unmarried child for whom a court has ordered the employee (and/or the employee's legal spouse) to assume sole permanent custody. An eligible foster child is a child placed with an Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. A Child will be eligible for coverage under the Plan until the end of the year in which he or she turns age 26. Biological children, stepchildren, and adopted children will be eligible for coverage until age 26 without regard to student status, marital status, financial dependency or residency status with the Employee or any other person, except that stepchildren may only be eligible for coverage under the Plan as long as a natural parent remains married to the Employee. Foster children and other children for whom a court has ordered the employee (and/or the employee's legal spouse) to assume sole permanent custody may be covered until the end of the year in which they turn 26 provided their principal place of residence is with the employee; they are a member of the employee's household; they receive over one-half of their support from the employee; and custody (or placement in the case of foster children) was awarded (or made) prior to the child's 18th birthday.

Claims Administrator
is the third party administrator appointed by the Plan to process and administer the claims under the Plan. The Claims Administrator for the Plan is listed in Appendix A.

Coinsurance
is the percentage of the Maximum Allowed Amount participants pay for some Covered Services.

Copayment
is the fixed dollar amount participants pay for some Covered Services.

Cost Awareness (for KeyCare PPO members)
Covered Persons are individuals designated by the Employer (in accordance with the guidelines set by the Claims Administrator) who do not have reasonable access to KeyCare PPO Network Providers and facilities due to their location.

Covered Persons
are the Employee and enrolled eligible Dependents.

Covered Services
are those Medically Necessary hospital and medical services which are described as covered in this Plan Document and which are performed, prescribed or directed by a physician.

Deductible
is a fixed dollar amount of Covered Services participants pay in a calendar year before the health plan will pay for any remaining Covered Services during that calendar year.

Dependent
A covered Employee's Spouse; a covered Employee's Child; a covered Employee's Qualified Dependent under a Qualified Medical Child Support Order; a covered Employee's Child or Qualified Dependent who is totally disabled.

Effective Date
is the date coverage begins for the participant and/or his Dependents enrolled under the health plan.

Emergency Medical Condition (Emergency)
is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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.

Emergency Services (Emergency Care)
with respect to an emergency medical condition:

- 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 such emergency medical condition, and
- within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "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.

Enrollment Date
means a participant's first day of coverage under the County of Henrico's health plan. Refer to Section 4.1 of this Plan Document for more information.

Employee
means a regular full-time or part-time, active Employee of the Employer. An Employee is considered to be regular full-time or part-time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer.

Employer
means The County of Henrico, Virginia, or
The County School Board of Henrico County, Virginia, or
Economic Development Authority of Henrico County, Virginia

Experimental/Investigative
means any service or supply that is judged to be experimental or investigative at the Claims Administrator's sole discretion. Refer to **Exhibit A** for more information.

First-tier Drugs
have the lowest Copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.

Future Moms
is a program designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery.

Group Administrator
is the benefits administrator at Henrico County General Government and Henrico County Public Schools.

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

Home Care Services
are services rendered in the home Setting. Home care includes services such as skilled nursing Visits and physical, speech, and occupational therapy for patients confined to their homes. This also means infusion services rendered in the home Setting. Infusion services include the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Infusion services rendered in the home Setting do not require that the patient is confined to his/her home.

Inpatient
means when an individual is a bed patient in the hospital.

Inpatient Facilities
are Settings where patients can spend the night, including hospitals, Skilled Nursing Facilities, and partial day programs.

KeyCare PPO Network (applies to KeyCare PPO Plan)
is a network of Providers and facilities that has agreed to accept the Claims Administrator's Maximum Allowed Amount as payment in full for their services (see this section for a definition of Maximum Allowed Amount). When a participant receives care from KeyCare PPO Network Providers and facilities, the participant will not be charged for any outstanding balances beyond his Deductible (if any), Copayment, and/or Coinsurance amount for Covered Services detailed in the Schedule of Benefits (refer to the Schedule of Benefits for the PPO Plan in Section 7 of this Plan Document.)

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

Maximum Allowed Amount
means the amount on which Deductible (if any), Copayment, and Coinsurance amounts for eligible services are calculated.

Medical Equipment (Durable)
is used for a medical purpose, can withstand repeated use, and is appropriate for use in a participant's home for Activities of Daily Living purposes.

Medically Necessary
to be considered Medically Necessary, a service must:

- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of a participant's condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the Provider.

Mental Health Services
are for the diagnosis and treatment of a psychiatric condition, including nervous, mental, and emotional disorders, and alcohol and drug abuse.

Out-of-Network
Refers to services from Providers not participating in the network. These services are covered at a lower level of benefits. After a participant satisfies a calendar year Deductible, he is responsible for the Coinsurance.

Outpatient
is when a participant receives care in a Setting such as a hospital Outpatient department (when he is not considered Inpatient), emergency room, professional Provider's office, free-standing surgical center, or his home.

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

Partial Day Services
are used as an alternative to Inpatient treatment.

Placed for Adoption
refers to a Child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

Plan Administrator
The County of Henrico, Virginia
The County School Board of Henrico County, Virginia

Post-service Claims
are all claims other than Pre-service Claims and Urgent Care Claims. Post-service Claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where a participant requests authorization in advance.

Prescription Drugs
are medicines, including insulin, that require a prescription order from a participant's doctor.

Pre-service Claims
are claims for a service where the terms of the health plan require the participant to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If the participant calls to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.

Provider
is a medical group, physician, hospital, Skilled Nursing Facility, pharmacy, or any other duly licensed institution or health professional who has contracted with the POS, Lumenos HSA, or PPO or its designee to provide Covered Services to participants and their covered Dependents.

Qualified Beneficiary
is a Covered Person who is eligible for a temporary extension of coverage under a participant's health plan because of the COBRA law.

Qualified Dependent
Any Child of a Plan participant who is an alternate recipient under a Qualified Medical Child Support Order shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

Qualifying Event
is an event that allows an Employee or Covered Persons enrolled with the Employee to select continuation of coverage under the COBRA law.

Retail Health Clinic
is a clinic that provides limited basic medical care services on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by physician’s assistants and nurse practitioners.

Second-tier Drugs
will have a higher Copayment than First-tier drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.

Setting
is the place where participants receive treatment. It could be their home, their Provider’s office, a hospital Outpatient department, a skilled nursing home, hospital Inpatient room, or a partial day program.

Skilled Nursing Facility
is a facility licensed by the state in which it operates to provide medically skilled services to Inpatients.

Spouse
means the person recognized as the covered Employee's husband or wife under the laws of the Commonwealth of Virginia. The Plan Administrator may require documentation proving a legal marital relationship.

Stay
is the period from the admission to the date of discharge from a facility, including hospitals, hospices, and Skilled Nursing Facilities. All facility Stays, less than 90 days apart are considered the same Stay, and a new Inpatient Copayment will not apply.

Telemedicine Services
means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Telemedicine Services do not include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

Third-tier Drugs
will have a higher Copayment than Second-tier Drugs. This tier will contain non-preferred or high cost medications. This tier may include generic, single source, or multi-source brand drugs.

Urgent Care
medical care for situations that are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury. Examples of Urgent Care situations include high fever, vomiting, sprains or minor cuts.

Urgent Care Claims
are claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient’s life, health or ability to regain maximum function, or in the opinion of the patient’s physician, would subject the patient to severe pain. Notwithstanding any provision of the health plan, services for an emergency medical condition do not require PCP referrals or any type of advance approval.

Visit
a period during which a Covered Person meets with a Provider to receive Covered Services.

SECTION 3
INFORMATION ABOUT THE PLAN

3.1 IDENTIFYING INFORMATION

Name of the Plan
The name of the Plan is the County of Henrico Health Plan.

Effective Date of the Plan
The initial Effective Date of the Plan is January 1, 2008.

Plan Year
The Plan Year begins January 1st and ends on the following December 31st, and Plan records are maintained on that basis.

Employer
This Plan covers eligible Employees of:
The County of Henrico, Virginia EIN: 54-6001344
The County School Board of Henrico County, Virginia EIN: 54-6001344
Economic Development Authority of Henrico County, Virginia EIN: 54-1197472

Type of Plan
Health

Name and Address of Plan Sponsor and Plan Administrator
County of Henrico, Virginia
4301 East Parham Road
Henrico, VA 23228

Claims Administrator and Customer Service Contact
The Plan has appointed a third-party administrator to process claims and administer the day-to-day operations of the Plan. The name of the third-party administrator and its contact information is included in Exhibit A of this document.

Delegation of Duties to Claims Administrator
The County has delegated to the Claims Administrator the authority (1) to determine eligibility for Plan benefits and (2) to interpret coverage of benefits under the Plan in connection with the decision to pay claims and the administration of appeals of claims denied, in whole or in part, as such reviews are required under applicable state and federal laws. The Claims Administrator shall interpret the language of the Plan in accordance with a uniform benefit coverage standard across localities, regions, and state lines regardless of the Plan Participant's geographic location. Any determination or interpretation made by the Claims Administrator pursuant to this discretionary authority shall be given full force and effect and be binding on the Employer and Participant, subject to applicable state and federal laws. The Claims Administrator serves as a fiduciary of the Plan for the limited purpose of providing claims administration services.

3.2 FUNDING MEDIUM/SOURCE OF CONTRIBUTIONS

The Plan is funded through Employer and Employee contributions.

SECTION 4
GENERAL PROVISIONS

4.1 ELIGIBILITY

Eligible Classes of Employees

A person is eligible for Employee coverage on the first day of the month following date of employment if he or she is a regular full-time or part-time, active Employee of the Employer. An Employee is considered to be regular full-time or part-time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer.

Eligible Classes of Dependents

A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the Commonwealth of Virginia. The Plan Administrator may require documentation proving a legal marital relationship.

An Employee may cover a Dependent who is 65 years or older under this Plan until the Active Employee retires. Upon retirement of the Active Employee, such Dependent may enroll in a separate, Medicare Advantage or Medicare Supplement health plan through a County sponsored enrollment service.

(2) A covered Employee's Child.

Child includes a biological child, stepchild, adopted child or child placed for adoption, an eligible foster child, or other unmarried child for whom a court has ordered the employee (and/or the employee's legal spouse) to assume sole permanent custody.

An eligible foster child is a child placed with an Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

A Child will be eligible for coverage under the Plan until the end of the month in which he or she turns age 26. Biological children, stepchildren, and adopted children will be eligible for coverage until age 26 without regard to student status, marital status, financial dependency or residency status with the Employee or any other person, except that stepchildren may only be eligible for coverage under the Plan as long as a natural parent remains married to the Employee. Foster children and other children for whom a court has ordered the employee (and/or the employee's legal spouse) to assume sole permanent custody may be covered until the end of the month in which they turn 26 provided their principal place of residence is with the employee; they are a member of the employee's household; they receive over one-half of their support from the employee; and custody (or placement in the case of foster children) was awarded (or made) prior to the child's 18th birthday.

Placed for Adoption refers to a Child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the Child in anticipation of

adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

(3) A covered Employee's Qualified Dependents.

Any Child of a Plan participant who is an alternate recipient under a Qualified Medical Child Support Order shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age of 26 and is Totally Disabled, incapable of self-sustaining employment by reason of behavioral or physical handicap, primarily dependent upon the covered Employee for support and maintenance, and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the divorced former Spouse of the Employee; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both. If both husband and wife are Employees, each may enroll as an Employee or as an eligible Dependent of the other, but not as both.

Eligibility Requirements for Dependent Coverage

A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

Eligible Classes of Retirees

Retirees who leave service with an immediate (non-deferred) VRS monthly retirement benefit and who are not Medicare eligible because of age may enroll in Retiree coverage under this Plan until they reach age 65. When such retirees reach age 65, they become ineligible for coverage under this Plan, but they may enroll in a separate Medicare Advantage or Medicare Supplement health plan through a County sponsored enrollment service.

Retirees who leave service with an immediate (non-deferred) VRS monthly retirement benefit and who are Medicare eligible solely due to disability may enroll in Retiree coverage under this Plan until they reach age 65. When such retirees reach age 65, they become ineligible for coverage under this Plan, but they may enroll in a separate Medicare Advantage or Medicare Supplement health plan through a County sponsored enrollment service.

Retirees who leave service without an immediate (non-deferred) VRS monthly retirement benefit are not eligible for coverage under this Plan or enrollment in a separate Medicare Advantage or Medicare Supplement health plan through a County sponsored enrollment service.

A Retiree’s Dependent who is not Medicare eligible because of age may enroll in Retiree coverage

under this Plan until the Dependent reaches age 65. When such Dependent reaches age 65, the Dependent becomes ineligible for coverage under this Plan but may enroll in a separate Medicare Advantage or Medicare Supplement health plan through a County sponsored enrollment service.

A Retiree's Dependent who is Medicare eligible solely due to disability may enroll in Retiree coverage under this Plan until the Dependent reaches age 65. When such Dependent reaches age 65, the Dependent becomes ineligible for coverage under this Plan but may enroll in a separate Medicare Advantage or Medicare Supplement health plan through a County sponsored enrollment service.

Eligible Retirees must enroll for coverage within 31 days of termination of employment or within 31 days of the loss of Active Employee coverage. Retirees who do not enroll for coverage during their initial eligibility period will not be allowed to enroll at a later date. They will not be allowed to re-enter the Health Plan once they have terminated coverage.

Eligible Survivors of Retirees
If a covered Retiree dies, the following family members are eligible to continue coverage as outlined below:

- The Retiree's surviving Spouse (if covered under the Plan at the time of the Retiree's death) is eligible to continue coverage for the remainder of his/her lifetime as long as the Spouse's required premium is paid timely.
- The Retiree's surviving children (if covered under the Plan at the time of the Retiree's death or if born to the Retiree's surviving Spouse after the Retiree's death) are eligible to continue coverage through the end of the month in which they turn age 26 as long as the surviving Spouse remains covered under this Plan. However, the surviving Child(ren)'s eligibility for coverage will end before they turn age 26 if one of the following events occur earlier:
    - Failure to pay the Child(ren)'s required premium timely.
    - The Child or Children waive coverage.
    - The surviving Spouse dies. COBRA coverage would be offered to the surviving Child(ren) for 36 months following the death of the Surviving Spouse.
    - The surviving Spouse's coverage terminates for any reason (including failure to pay the surviving Spouse's required premium or the Surviving Spouse's voluntary waiver of coverage).
    - If Children are covered but a Spouse is not covered at the time of the Retiree's death, the surviving Child(ren) will be offered COBRA coverage for 36 months following the Retiree's death.
- If a Retiree's surviving Child(ren) loses coverage because he/she attains the age limit of 26, he/she will be offered COBRA coverage for 36 months from the date of coverage loss.
- If a Retiree's surviving Spouse remarries, he/she will not have the right to cover his/her new Spouse under the plan.
- The surviving Spouse will not have the right to cover Children who are not the Retiree's Children under the Plan after the Retiree dies.

4.2 ENROLLMENT

Enrollment Requirements for Employees
An Employee must enroll timely for coverage by using the method available at the time of enrollment: either 1) completing an enrollment form, or 2) enrolling electronically.

Enrollment Requirements for Newborn Children
A newborn Child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care and routine Physician care will be applied toward the Plan of the newborn Child. The newborn Child must be enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, or there will be no payment from

the Plan and the parents will be responsible for all costs.

Timely Enrollment
The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

Enrollment Requirements for Retirees
A Retiree must enroll for coverage by submitting a completed enrollment form within 31 days of the date of termination of employment or within 31 days of the loss of Active Employee coverage. Enrolled Retirees may add or drop Dependents within 31 days after the Dependent(s) become eligible under a Special Enrollment period or cease to become eligible Dependents.

4.3 HIPAA SPECIAL ENROLLMENT RIGHTS

HIPAA provides Special Enrollment provisions under some circumstances. If an Employee has declined enrollment for himself or his Dependents (including his Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage. However, a request for enrollment in this Plan must be made within 31 days after the other coverage ends.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information regarding these portability provisions, contact the Human Resources Benefits Division (General Government) at (804) 501-7371 or the Health Benefits Office (Schools) at (804) 652-3624. Employees of Economic Development Authority should contact the Human Resources Benefits Division (General Government) at (804) 501-7371.

Special Enrollment Periods
The Enrollment Date for anyone who enrolls under a HIPAA Special Enrollment period is the first date of coverage.

(1) Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll within 31 days of loss of eligibility for other coverage under the following circumstances:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual. However, Special Enrollment will be available to Employees who decline group health coverage without having coverage under another health plan and subsequently enroll in other coverage and lose that coverage.

(b) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions towards the coverage were terminated.

(c) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

(ii) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example, part-time Employees).

(iii) The Employee or Dependent has a loss of eligibility as a result of divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through a POS (or other arrangement) that does not provide benefits to individuals who no longer reside, live or work in a Service Area (whether or not within the choice of the individual).

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a Child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to be enrolled.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

The Dependent Special Enrollment period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Employee must request enrollment for himself (if not already enrolled) and for the Dependent during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first of the month following the date of the marriage or following receipt of the enrollment request, whichever is later. Enrollment requests must be received within 31 days of the marriage date;

(b) in the case of loss of coverage, the first of the month following the date of the loss of prior coverage if the Employee completes and returns the enrollment/change form in a timely manner and pays any required premiums for such new coverage;

(c) in the case of a Dependent's birth, as of the date of birth; or

(d) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Other Special Enrollment Periods
Eligible Employees and their Dependents, who are not enrolled in the group health plan, may enroll for coverage if either of the following conditions is met:

(1) The Employee/Dependents' Children's Health Insurance Program (CHIP) or Medicaid coverage is terminated due to loss of eligibility and the Employee requests coverage under the group health plan within 60 days after his and/or his Dependents' loss of coverage under Medicaid or the CHIP; or

(2) The Employee/Dependent becomes eligible for premium assistance from the CHIP or Medicaid and requests coverage under the group health plan within 60 days after the date that the CHIP or Medicaid determines that the Employee/Dependent is eligible for such assistance.

The Employee also has the right to terminate his and/or his Dependents' enrollment in the group health plan and enroll in Medicaid or the CHIP.

4.4 UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)

In accordance with Federal law, certain Employees who return to employment following active duty service as a member of the United States Reserves or National Guard will be reinstated to coverage under the Plan (for themselves and any Dependents who were covered prior to the military assignment). No new waiting period requirement will apply, except for any waiting period still remaining from prior to the active military assignment. However, this provision is intended to comply with the minimum requirements of the USERRA and, if it is in conflict or incomplete in any way, such law (38 U.S.C. Section 4301) will prevail.

4.5 ENROLLMENT OF DEPENDENT PURSUANT TO A QUALIFIED MEDICAL CHILD SUPPORT ORDER

If the Plan Administrator receives a Qualified Medical Child Support Order (QMCSO), as determined by the Plan Administrator, for an eligible Dependent, the Effective Date shall be the later of (a) the date of the QMCSO, or (b) thirty (30) days prior to the date the QMCSO was received by the Plan Administrator. If the Employee is not enrolled in the Plan, the Plan Administrator shall enroll the Employee as of the same Effective Date as the eligible Dependent and the Employee shall be responsible for any required Employee contributions.

4.6 EFFECTIVE DATE OF COVERAGE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date of hire in which the Employee satisfies all of the following:

(1) The Eligibility Requirement (see Section 4.1).

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined in Section 4.1 of this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that (1) the Eligibility Requirements are met,(2) the Employee is covered under the Plan, and (3) all Enrollment Requirements are met.

4.7 TERMINATION OF COVERAGE

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of the following dates:

(1) The date the Plan is terminated.

(2) The end of the month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability or leave of absence unless the Plan specifically provides for continuation during these periods. If the Employee contribution for the month in which employment terminates has not been paid when due, then coverage will be terminated as of the last day of the preceding month.

(3) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect or may immediately terminate coverage.

When an Employee's coverage terminates, he may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled Continuation Coverage Rights under COBRA.

When Retiree Coverage Terminates. Retiree coverage under this Plan will terminate at the earliest of the following events:

(1) The retiree fails to pay the required premium contribution.

(2) The retiree sends written notification that coverage is no longer desired.

(3) The retiree dies.

(4) The retiree becomes eligible for Medicare due to age.

(5) The County of Henrico terminates the plan, in which case a participating retiree may enroll in another County-sponsored retiree plan.

(6)The retiree fails to enroll in the plan in a timely manner during the annual open enrollment period.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. Coverage will continue as follows:

For disability leave only: If the Employee is protected by FMLA or is using earned sick leave or other paid leave, coverage continues during the period of leave. However, the Employee must pay the required premium for health insurance coverage to the benefits office each month if the Employee is not receiving pay from which a payroll deduction can be made. If the Employee is not protected by FMLA or is not using earned sick leave or other paid leave, the Employee is not entitled to the County's premium contribution and must pay the full cost of the required premium for health insurance each month. If payment is not made, then coverage will terminate at the end of the last month for which the required premiums have been paid, and the Employee may continue coverage through COBRA. (See the section entitled Continuation Coverage Rights under COBRA.)

For leave of absence or layoff only: If the Employee is not protected by FMLA or is not using earned sick leave or other paid leave, the Employee is not entitled to the County's premium contribution and must pay the full cost of the required premium for health insurance each month. If payment is not made, then coverage will terminate at the end of the last month for which the required premiums have been paid, and the Employee may continue coverage through COBRA. (See the section entitled Continuation Coverage Rights under COBRA.)

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay the Employee contribution under the Plan.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of the following dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The end of the month in which the Employee's coverage under the Plan terminates for any reason (or date of death). (See the section entitled Continuation Coverage Rights under COBRA.) If the Employee contribution for the month in which employment terminates has not been paid when due, then coverage will be terminated to the last day of the preceding month.

(3) The end of the month in which a covered Spouse is no longer a Dependent. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) The end of the month in which a Dependent Child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The date on which the Plan voids coverage for the Dependent because the Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Plan may either void coverage for the Dependent for the period of time coverage was in effect or may immediately terminate coverage.

(6) The date after thirty-one (31) days written notice from the Plan that a Dependent misused the Plan identification card or allowed persons other than the one specifically named on the ID card to attempt to obtain benefits.

When a Dependent's coverage terminates, he may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA.

4.8 PATIENT PROTECTION NOTICE

The County of Henrico Health Plan does not require plan participants to designate a Primary Care Physician (PCP). To receive benefits at the in-network level, Plan Participants have the right to seek services from any PCP who participates in the Network and who is available to accept new patients. For a list of Participating Primary Care Physicians, contact the Claims Administrator at the Customer Service number printed on the Plan's ID card.

SECTION 5
PARTICIPANT RIGHTS AND RESPONSIBILITIES

5.1 PARTICIPANTS' RIGHTS

Participants of the Health Plan have the right to:

- Be provided with accurate information about the Plan's services, benefits, and about their rights and responsibilities as Plan Participants.
- Be provided with accurate information about Participating Providers.
- Participate with their Physician in decisions made regarding their health care.
- Discuss appropriate or Medically Necessary treatment options for medical conditions.
- To use advance directives in directing their health care, including living wills and power of attorney for health care documents.
- Access the Claims Administrator's Customer Services Department.
- Be treated with respect and recognition of their dignity and need for privacy and confidentiality.
- Voice complaints and submit appeals about the Health Plan, the Claims Administrator, or the care provided by Participating Providers and to have a clear, documented method for addressing any complaints and appeals.

5.2 PARTICIPANTS' RESPONSIBILITIES TO PROVIDERS

Participants of the Health Plan have the responsibility for cooperating with Providers of health care services by:

- Providing information needed by health care professionals.
- Informing the Provider's office and facility staff of their coverage with this Health Plan and notifying the Provider's staff if they disenroll.
- Following instructions and guidelines given by health care Providers.

5.3 PARTICIPANTS' RESPONSIBILITIES TO KNOW HOW AND WHEN TO SEEK CARE

Health Plan Participants have the responsibility of knowing their health benefits, as well as any procedures required for seeking care, such as:

- Knowing the benefit plan option in which they and their family members are currently enrolled.
- Knowing whether they are seeking care from a Participating or Non-Participating Provider. In most cases, benefits will vary according to the participation status of the Provider delivering Covered Services.
- Verifying the current participation status of any Provider for their specific benefit plan prior to receiving services.
- Always obtaining any required authorizations as described in Section 8 of this Plan Document for Medical Benefits and Section 9 of this document for Prescription Drug Benefits. When seeking services from a Non-Participating Provider, Participants will need to ensure that the Claims Administrator, on behalf of the Plan, has approved the services before receiving services.
- Understanding the terms and limitations of Preauthorizations for Covered Services and whether Preauthorizations are approved at the In-Network or Out-of-Network benefit level .
- Obtaining Preauthorization from the Claims Administrator, on behalf of the Plan, prior to continuation of care if they or a covered family member are receiving health care from a Non-Participating Provider when they enroll.
- Accessing Behavioral Health and Substance Abuse services as described in this Plan Document.
- The responsibility of promptly notifying Human Resources Benefits Division (General Government) or Health Benefits Office (Schools) and the Claims Administrator of any address

or telephone number changes. Health Plan Participants at the Economic Development Authority should notify Human Resources Benefits Division (General Government).

- Checking with Human Resources Benefits Division (General Government) or Health Benefits Office (Schools) regarding Dependent eligibility and notifying Human Resources Benefits Division (General Government) or Health Benefits Office (Schools) and the Claims Administrator within thirty-one (31) days of any changes. Health Plan Participants at the Economic Development Authority should contact and notify Human Resources Benefits Division (General Government).
- Making sure all family members are aware of the correct procedures for obtaining the Health Plan coverage described in this Plan Document and administered by the Claims Administrator.
- Failure to meet the responsibilities listed in this Plan Document may cause Health Plan Participants to be held financially responsible for services provided.

SECTION 6
HOW THE HEALTH PLAN WORKS

The Plan provides a wide range of health care services within a special network of health care Providers and facilities. Participants will receive benefits based on where they receive health care services and the limits stated in the Schedule of Benefits (see Section 7) and related exclusions. The Plan has entered into an administrative services contract with the Claims Administrator to carry out certain functions with respect to claims operation.

Carry the Health Plan ID card
The Health Plan ID card identifies each Plan participant as a Covered Person and contains important health care coverage information. When a participant shows his ID card to his doctor, hospital, pharmacist, or other health care Provider, they will file claims for him in most cases. Carrying the ID card at all times will ensure that a participant always has this coverage information with him when he needs it.

6.1 IF A PLAN PARTICIPANT IS ENROLLED IN THE POS PLAN OR THE HIGH DEDUCTIBLE HEALTH PLAN WITH HSA (THE PPO PLAN IS DISCUSSED BEGINNING ON PAGE 28).

Note: The network of participating Providers (the HealthKeepers network) is the same for the POS plans and the High Deductible Health Plan with HSA.

Primary Care Physicians ("PCP")
A participant's PCP will provide his primary health care services such as annual physicals and medical tests, oversee care when he is ill or injured, and treat any chronic health problems or diseases. Participants should establish a personal and continuous relationship with their PCP. Building and maintaining this ongoing relationship is an important part of health care.

A participant's coverage does not require that he obtain a referral from his PCP to receive care from other health plan Providers. However, he may want to let his PCP know about other Providers that are treating him so that his PCP can better oversee his health care.

The advance approval process
HealthKeepers network Providers are required to obtain prior authorization in order for a Plan participant to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The health plan may determine that a service that was initially prescribed or requested is not Medically Necessary if a participant has not previously tried alternative treatments which are more cost effective.

The health plan will make coverage decisions on services requiring advance approval within 15 days from the receipt of the request. The health plan may extend this period for another 15 days if the health plan determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, participants will be notified prior to the expiration of the initial 15-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, the health plan will make its decision within 2 working days of its receipt of all necessary clinical information needed to process the advance approval request.

For Urgent Care Claims, coverage decisions will be completed and the health plan will respond to participants and their Providers as soon as possible taking into account the medical condition, but not later than 72 hours from receipt of the request. If insufficient information is submitted in order to review the claim, the health plan will ask the participant or his Provider for the information needed within 24 hours of the receipt of the participant's request, and make a decision within 48 hours of receiving the information. If the requested information is not received within 48 hours of the request, the health plan will make a decision within 96 hours from the date of the request.

Once the health plan has made a coverage decision on services requiring advance approval, participants will receive written notification of the coverage decision. In the event of an Adverse Benefit Determination, the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of the health plan's appeal procedures and applicable time limits;
- in the case of an Urgent Care Claim, a description of the expedited appeal and expedited review process applicable to such claims; and
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist participants with the internal or external appeals process.

If all or part of a pre-service or Urgent Care Claim care claim was not covered, participants have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the health plan relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, participants are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition.

The health plan may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if, in the health plan's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, the health plan may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The health plan may also exempt a participant's claim from medical review if certain conditions apply.

Just because the health plan exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that the health plan will do so in the future, or will do so in the future for any other Provider, claim or member. The health plan may stop or modify any such exemption with or without advance notice.

Plan participants may determine whether a Provider is participating in certain programs by checking the Provider directory or contacting the customer service number on the back of their ID card.

Approvals of care involving an ongoing course of treatment

HealthKeepers network Providers must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If a participant is receiving care from a non-network-Provider and needs to receive an extension of a previously approved course of treatment, he will be required to ask for the extension. Participants should request the extension at least 24 hours prior to the end of the authorized timeframe to avoid disruption of care or services. The health plan will notify the participant of the coverage decision within 24 hours of his request.

If the health plan makes a determination to reduce or terminate benefits for all or any part of a previously approved course of treatment prior to its conclusion, this will be considered an Adverse Benefit Determination. If the reduction or termination was not a result of a health plan amendment or health plan termination, the health plan will notify the participant in advance of the reduction or termination in sufficient time for him to file an internal appeal prior to the reduction or termination

Non-network Providers
In the event that a participant receives Covered Services from a non-network Provider, then the health plan reserves
the right to make payment of such Covered Services directly to the participant, the non-network Provider, or any other person responsible for paying the non-network Provider's charge. In the event that payment is made directly to the participant, he has the responsibility to apply this payment to the claim from the non-network Provider. If the participant receives services from a non-network Provider without the proper authorization, he will be responsible for the charges for the services.

Terminated Providers
The HealthKeepers network is subject to change as health care Providers are added to the network, move, retire, or change their status. When Providers decide to leave the network, they become non-participating Providers, and their services, unless properly authorized, will be covered at the out-of-network benefit level.

There are two instances when members may continue seeing Providers who have left the network and receive coverage at the in-network benefit level

1. A member in the second or third trimester of pregnancy may continue seeing her obstetrician-gynecologist through postpartum care for that delivery.
2. Members with life expectancy of six months or less may continue seeing their treating physician.

Guest Memberships (for members temporarily outside of the service area)
When an Employee or any of his Dependents will be staying temporarily outside of the service area for more than 90 days, the participant can request a guest membership to a Blue Cross and
Blue Shield affiliated HMO/POS in that area. An example of when this service may be utilized is when a Dependent student attends a school outside of the service area. A participant may call a
Member Services representative to make sure that the area in which he or his
Dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated HMO Plans. If the area is within the network, the participant will need to complete a guest membership application and he will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield HMO affiliate where he or his covered Dependents will be staying. Member Services will explain any limitations or restrictions to this benefit. If a participant is staying in an area that is not within the Guest Membership Network, this service will not be available.

The difference between Emergency Care and Urgent Care
An emergency is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including severe pain that, without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the mental or physical health of the individual;
- danger of serious impairment of the individual's body functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Urgent Care situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury. Examples of Urgent Care situations include high fever, vomiting, sprains or minor cuts.

When participants need to access health care (within the service area)

- Medical care is available through a participant's PCP 7 days a week, 24 hours a day. If a participant needs care after regular office hours he may contact the on-call PCP or the 24/7 NurseLine. For instructions on how to receive care, a participant may call his PCP or the 24/7 NurseLine.

- If a participant's condition is an emergency, he should be taken to the nearest appropriate medical facility.
- A participant's coverage includes benefits for services rendered by Providers other than network Providers when the condition treated is an emergency as defined in this Plan Document.

When participants are away from home (outside the service area) and need to access care
The POS does business only within a certain geographic area in the Commonwealth of Virginia. See **The BlueCard Program** below for Covered Services received outside of Virginia. Urgent Care and Emergency Services outside the service area are provided to help participants if they are injured or become ill while temporarily away from the service area. Benefits for these services are limited to care which is required immediately and unexpectedly. Elective care and care required as a result of circumstances which could reasonably have been determined prior to leaving the service area are not covered. Benefits for maternity care do not cover normal term delivery outside the service area, but do include earlier complications of pregnancy or unexpected delivery occurring outside the service area.

If an Emergency Care or Urgent Care situation occurs when a participant is temporarily outside the service area:

- he should obtain care at the nearest medical facility;
- he will be responsible for payment of charges at the time of his Visit; and
- he should obtain a copy of the complete itemized bill for filing a claim with the health plan.

Out-of-Area Services
The POS has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever participants obtain health care services outside of the POS service area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside the POS service area and the service area of the POS's corporate parent, participants will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, participants may obtain care from non-participating health care Providers. The POS's payment practices in both instances are described below.

The POS covers only limited health care services received outside of the POS service area. "Out-of-Area Covered Health Care Services" include Emergency Care and Urgent Care obtained outside the geographic area the POS serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by a participant's primary care physician ("PCP").

The BlueCard® Program
Under the BlueCard® Program, when participants obtain Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, the POS will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

The BlueCard Program enables participants to obtain Out-of-Area Covered Health Care Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating health care Provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to participants, so there are no claim forms for participants to fill out. Participants will be responsible for the Copayment amount, as stated in their Schedule of Benefits.

Emergency Care Services: If a participant experiences a Medical Emergency while traveling outside the POS service area, he should go to the nearest Emergency or Urgent Care facility.

Whenever a participant accesses covered health care services outside the POS service area and the

claim is processed through the BlueCard Program, the amount a participant pays for covered health care services, if not a flat dollar Copayment, is calculated based on the lower of:

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

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

Notification
The POS will participate in coordinating a participant's care if he is hospitalized as a result of receiving Emergency Services. He or a representative on his behalf should notify the POS within 48 hours after he begins receiving care. **This applies to services received within or outside the service area.**

Hospital admissions
All non-emergency hospital admissions must be arranged by the participant's admitting POS physician and approved in advance by the POS, except for maternity admissions as specified in Section 6 of this Plan Document. The POS also reserves the right to determine whether the continuation of any hospital admission is Medically Necessary. For emergency admissions, refer to the preceding paragraph **Notification.** The POS will respond to a request for hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. The POS may extend this period for another 15 days if the POS determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, a participant will be notified prior to the expiration of the initial 15-day period.

In cases where the hospital admission is an Urgent Care Claim, a coverage decision will be completed within 24 hours. The participant's physician will be notified verbally of the coverage decision within this timeframe. Once a coverage decision has been made regarding the participant's hospital admission, he will receive written notification of the coverage decision. In the event of an Adverse Benefit Determination, the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration along with an explanation of why the requested material or information is needed;
- a description of the POS's appeal procedures and applicable time limits;
- in the case of an Urgent Care Claim, a description of the expedited review process applicable to such claims; and
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist the participant the internal or external appeals process.

If all or part of a hospital admission was not covered, a participant has a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the POS relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, a participant is entitled to receive upon request, and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to his medical condition.

The length of Stay for hospital admissions for mastectomies, maternity admissions and hysterectomies is governed by federal law. Please see this Plan Document for more detail.

6.2 IF A PLAN PARTICIPANT IS ENROLLED IN THE PPO PLAN (The POS PLAN AND HIGH DEDUCTIBLE HEALTH PLAN WITH HSA ARE DISCUSSED BEGINNING ON PAGE 22).

Covered Providers and facilities
The health plan covers certain care administered by Providers and facilities. To ensure benefits, Providers and facilities must be licensed in the state where they operate to perform the service a participant receives and the service must be covered by the participant's health plan. Certain services are covered by the Plan and rendered by other covered medical suppliers, such as suppliers of Medical Equipment (Durable), private duty nursing services, Prescription Drugs, ambulance services, etc.

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

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

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

Choose a health care Provider

In Virginia
Plan participants have the freedom to receive care from any Provider or facility. However, they receive the highest level of benefits when they receive care from Providers and facilities within the KeyCare PPO Network. Care received from KeyCare PPO Network Providers and facilities is considered in-network care. A participant's health plan provides coverage for certain services that do not have Providers within the networks. These services would be considered in-network services. An example is private duty nursing services.

Out-of-area services
The health plan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a participant obtains health care services outside of the 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 the service area, a participant will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, participants may obtain care from non-participating health care Providers. Payment practices in both instances are described below.

BlueCard® Program
Under the BlueCard® Program, when a participant accesses covered health care services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling their contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

Whenever a participant accesses covered health care services outside the service area and the claim is processed through the BlueCard Program, the amount the participant pays for covered health care services, is calculated based on the lower of:

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

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

How to find a Provider in the network

There are three ways participants can find out if a Provider or facility is in the network:

- Refer to the health plan's directory of network Providers at www.anthem.com, which lists doctors and health care facilities that participate in the health plan's network, as well as information about the standards of care in area hospitals.
- Call Member Services to request a list of doctors and health care facilities that participate, based on specialty and geographic area.
- Check with their doctor or health care facility.

All network Providers have a process in place to help participants access Urgent Care 24 hours a day, 7 days a week. If participants require Urgent Care after their doctor's normal business hours, they should call the office and they will be directed to needed care.

Out-of-Network care

Out-of-Network care is covered at a lower level of benefits than in-network care. After a participant satisfies a calendar year Deductible (if any), he is responsible for his Coinsurance, a percentage of the Maximum Allowed Amount as stated in the Schedule of Benefits (Section 7). If the Out-of- Network ambulance, Provider or facility participates in any Anthem network or other Blue Cross Blue Shield company's network, they will accept the Maximum Allowed Amount as payment in full for their services. However, ambulances, Providers and facilities that do not participate in any Anthem or Blue Cross Blue Shield company's network may bill the participant for the difference between their charge and the Maximum Allowed Amount.

The advance approval process

Network Providers are required to obtain prior authorization in order for participants to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Claims Administrator may determine that a service that was initially prescribed or requested is not Medically Necessary if a participant has not previously tried alternative treatments which are more cost effective.

A participant's health plan will make coverage decisions on services requiring advance approval (for example, Home Care Services, etc.), within 15 days from the receipt of the request. The participant's health plan may extend this period for another 15 days if it is determined it to be necessary because of matters beyond their control. In the event that this extension is necessary, participants will be notified prior to the expiration of the initial 15-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, a participant's health plan will make its decision within 2 working days of its receipt of all necessary clinical information needed to process the advance approval request.

For Urgent Care Claims, coverage decisions will be completed and the health plan will respond to the participant and his Provider as soon as possible taking into account his medical condition, but not later than 72 hours from receipt of the request. If insufficient information is submitted in order to review the claim, the health plan will ask the participant or his Provider for the information needed within 24 hours of the receipt of the participant's request, and make a decision within 48 hours of receiving the information. If the requested information is not received within 48 hours of the request, the health plan will make its decision within 96 hours from the date of the request.

Once the participant's health plan has made a coverage decision on services requiring advance approval, the participant will receive written notification of the coverage decision. In the event of an Adverse Benefit Determination, the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of the health plan's appeal procedures and applicable time limits;
- in the case of an Urgent Care Claim care claim, a description of the expedited appeal and expedited review process applicable to such claims; and
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist participants with the internal or external appeals process.

If all or part of a pre-service or Urgent Care Claim care claim was not covered, participants have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that their health plan relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, participants are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to the participant's medical condition.

The Claims Administrator may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in their discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, the Claims Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. They may also exempt a participant's claim from medical review if certain conditions apply.

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

A participant may determine whether a Provider is participating in certain programs by checking the health plan's on-line Provider directory or contacting customer service number on the back of his ID card.

Approvals of care involving an ongoing course of treatment

Network Providers must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If a participant is receiving care from a non-network Provider and needs to receive an extension of a previously approved course of treatment, he will be required to ask for the extension. A participant should request the extension at least 24 hours prior to the end of the authorized time frame to avoid disruption of care or services. The Claims Administrator will notify the participant of the coverage decision within 24 hours of his request.

If the health plan makes a determination to reduce or terminate benefits for all or any part of a previously approved course of treatment prior to its conclusion, this will be considered an Adverse Benefit Determination. If the reduction or termination was not a result of a health plan amendment or health plan termination, the health plan will notify a participant in advance of the reduction or termination in sufficient time for him to file an internal appeal prior to the reduction or termination.

In an emergency or if specialty care is not reasonably available in the network

If a participant has an emergency medical condition, he should go to the nearest appropriate Provider or medical facility. If the Provider or facility is not in the network, the participant or his network physician can call the Claims Administrator to have the Out-of-Network services authorized for the highest level of benefits. If specialty care is required and it's not available from a Provider within the network, the

participant's network Provider can call the Claims Administrator in advance of his receiving care to have the Out-of-Network services authorized for the highest level of benefits.

Hospital Admission Review
All hospital Stays, skilled nursing home Stays, or treatment in partial day programs should be approved before each admission. The exception to this is maternity admissions as specified in Section 6 of this Plan Document. If a participant is admitted to the hospital as a result of an emergency medical condition, his hospital Stay should be reviewed by the Claims Administrator within 48 hours of admission. The emergency room doctor, a relative, or a friend can call for Hospital Admission Review. Network Providers and facilities handle Hospital Admission Review for the participant. The participant must initiate the Hospital Admission Review process for out-of- network services. If a participant fails to obtain approval for an Inpatient Stay, and the Stay is later determined not to be Medically Necessary, he may have to pay the entire hospital bill in addition to any charges for services provided while he was an Inpatient. Strict adherence to this procedure may not be required for services that arise over the weekend.

Before a participant is admitted to the hospital for medical care or surgery, he or someone he authorizes must call the telephone number located on his identification card. Participants should have the following information available:

- their identification number (shown on their ID card);
- their doctor's name and phone number;
- the date they plan to enter the hospital and length of Stay; and
- the reason for hospitalization.

A participant's health plan will respond to a request for hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. The Claims Administrator may extend this period for another 15 days if it is determined to be necessary because of matters beyond their control. In the event that this extension is necessary, a participant will be notified prior to the expiration of the initial 15-day period.

In cases where the hospital admission is an Urgent Care Claim care claim, a coverage decision will be completed within 24 hours. A participant's physician will be notified verbally of the coverage decision within this time frame.

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

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of the health plan's appeal procedures and applicable time limits;
- in the case of an Urgent Care Claim care claim, a description of the expedited review process applicable to such claims; and
- the availability of, and contract information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist participants with the internal or external appeals process.

If all or part of a hospital admission was not covered, participants have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that their health plan relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, participants are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to their medical condition.

Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours. Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

The length of Stay for maternity admissions is determined according to the Newborn's and Mother's Health Protection Act. This federal law allows for 48 hours for vaginal delivery or 96 hours for caesarian section. Admissions for maternity care do not, initially, require Hospital Admission Review. However, if complications develop and additional days are necessary, Hospital Admission Review is required. The health plan requests that the participant's doctor contact the Claims Administrator to establish eligibility and waiting periods.

Admissions to hospitals located outside of Virginia
If a participant is admitted to a hospital outside of Virginia, he or someone on his behalf must initiate the Hospital Admission Review process. This applies in all cases, whether a participant lives, works, or travels outside of Virginia. If approval is not obtained for an Inpatient Stay and the Stay is later determined by the Claims Administrator not to be Medically Necessary, a participant may have to pay the entire hospital bill in addition to any charges for services provided while he was an Inpatient.

6.3 FOR ALL PLANS:

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

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

If a participant changed plans within the year
A participant's health plan may include calendar year limitations on Deductibles, out-of-pocket expenses, or benefits. These limitations may be affected by a change of health plan coverage during the calendar year.

- If a participant changes from this health plan to another employer's health plan during the calendar year, new limitations will apply as of the participant's Effective Date of coverage under the other employer's health plan. Amounts that may have accumulated toward similar limitations under the participant's former employer's health plan will not count toward the limitations under this health plan.

- If a participant does not change employers, but moves from the PPO plan option to the POS or High Deductible Health plan with HSA option during the calendar year, new limitations will apply as of the Effective Date of the participant's new coverage. Amounts that may have accumulated toward specific benefits or out-of-pocket requirements under the initial coverage will not count toward the limitations under the subsequent coverage.

- If a participant does not change employers, but moves from one POS plan option to another POS plan option during the calendar year, any amounts that had accumulated toward calendar year limitations before the change will count toward similar limitations under the new POS plan option for the remainder of the calendar year.

SECTION 7
SCHEDULES OF BENEFITS

All benefits described in the Schedules are subject to the exclusions and limitations described more fully herein including, but not limited to, the Claims Administrator's determination that: care and treatment is Medically Necessary; that charges are within the Maximum Allowable Charges; that services, supplies and care are not experimental and/or investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

The Schedules of Benefits for the following plans are included in this section.

- Premier POS Plan
- Standard POS Plan
- Lumenos Health Savings Account (HSA)
- PPO Plan
- Prescription Drug Plan
- Vision Plan

The Plan utilizes a Claims Administrator to administer many of the benefits described in this document. The Claims Administrator is listed in Exhibit A.

Please see the Section 6 How The Health Plan Works in this Plan Document for additional details. Certain services must be preauthorized or reimbursement from the Plan may be denied.

Henrico County General Government and Public Schools
Premier POS Plan/Open Access

Covered Services (not subject to deductible)	IN-NETWORK You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which may result in a member cost share.	***No Charge**
Doctor Visits	
• Office visits • Voluntary family planning • wisdom teeth extractions (bony impacted only) • in-office surgery • allergy testing	**$20** for each visit to your PCP or OB/GYN **$40** for each visit to a specialist
• urgent care visits	**$20** for each visit to your PCP **$40** for each visit to a specialist
• mammograms	**No Charge**
• mental health and substance abuse visits	**$20** for each visit
• allergy serum and allergy injections (if actual cost of serum and injection is less than the copay, member is only charged actual cost)	**$10** for each visit
Routine Vision	
• annual routine eye exam *Administered by Blue View Vision*	**$15** for each visit
Labs, Diagnostic X-rays	
• diagnostic tests • diagnostic x-rays (other than advanced diagnostic imaging services) • lab work* **Provided through LabCorp*	**No Charge**
Maternity Services	
• all routine outpatient pre-and postnatal care (excluding inpatient stays) • diagnostic testing (such as ultrasound, non-stress tests and other fetal monitor procedures)	**$50** per pregnancy **No Charge**
Emergency Care	
• true emergency care visits in or out of the service area **Waived if admitted directly to the hospital.*	**$150** for each visit to an emergency room*
Early Intervention – For children from birth through age 2	
• early intervention services	Member cost shares will be dependent on the services rendered.
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
• diagnosis and treatment of autism spectrum disorder including: - behavioral health treatment* - psychiatric care - therapeutic care** - pharmacy care - psychological care ** Mental Health Services* ***Unlimited physical, occupational and speech therapy.*	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
• nutritional counseling (maximum 5 visits per year)	**$45** benefit payable per visit
• ambulance travel	**No Charge**
• physical, occupational and speech therapy • spinal manipulation and manual medical therapy services (Limited to 30 visits per plan year)* **Administered by American Specialty Group (ASG)*	**$25** for each visit
- infusion therapy - chemotherapy - radiation therapy - dialysis	**No Charge**

All Other Services (subject to deductible)	
You will pay all the costs associated with your care until you have paid $150 per Individual / $150 per Family in one plan year. This is known as your deductible. *Once you reach your deductible you pay:*	
Inpatient Stays in a Hospital or Facility	
• semi-private room • private room when approved in advance • intensive or coronary care unit • maternity services • mental health and substance abuse services • occupational, speech and physical therapy	**$200** per day (not to exceed a maximum of **$1,000** per admission after deductible)
• skilled nursing facility (100 days for each admission)	**No charge** after deductible
Other Outpatient Services	
• advanced diagnostic imaging services (includes MRI, MRA, CTA and CT scans) done in an office setting	**$50** copay after deductible
• advanced diagnostic imaging services (includes MRI, MRA, CTA, PET scans and CT scans) done in all other settings	**$200** copay after deductible
• surgery in a hospital or facility (including bony impacted wisdom teeth extractions)	**$200** copay after deductible
• hospice care	**No charge** after deductible
• home health care (Limited to 90 visits per plan year)	**No charge** after deductible
• diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered after deductible.
• prosthetic devices	**No charge** after deductible
• durable medical equipment • medical supplies	**No charge** after deductible
• cardiac rehab therapy	**No charge** after deductible
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
• applied behavioral analysis	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after deductible, except for services related to preventive care)
Out-of-Network Services	
Deductible for services received from out-of-network health care professionals	
You will pay all of the costs associated with covered services until you pay $400 per Individual / $800 per Family in one plan year.	
Once you have reached this amount, when you receive covered services you will pay 30% and we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. What you pay includes any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges (this is referred to as balance billing). If you go to an eye care professional not in our Blue View Vision network for your routine eye examination, we will pay $30 (whether or not you have reached the out-of-network deductible) and you will pay the rest of what the professional charges.	

Out-of-Pocket Maximums
What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)
When using in-network professionals If you are the only one covered by your plan, you will pay $3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum. • If two people are covered under your plan, each of you will pay $3,000 ($6,000 total). • If three or more people are covered under your plan, together you will pay $6,000. However, no family member will pay more than $3,000 toward the limit. **When using out-of-network professionals** If you are the only one covered by your plan, you will pay $3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum. • If two people are covered under your plan, each of you will pay $3,000 ($6,000 total). • If three or more people are covered under your plan, together you will pay $6,000. However, no family member will pay more than $3,000 toward the limit. **The following do not count toward the calendar year out-of-pocket maximum:** • the cost of care received when the benefit limits have been reached • the cost of services and supplies not covered under this plan • the cost associated with vision services

SPECIALIST VISITS DO NOT REQUIRE PCP REFERRAL.

Some benefits may be subject to balance billing, if provided by a non-participating provider.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Henrico County General Government and Public Schools
Standard POS Plan/Open Access

Covered Services (not subject to deductible)	IN-NETWORK You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which may result in a member cost share.	***No Charge**
Doctor Visits	
• office visits • voluntary family planning • wisdom teeth extractions (bony impacted only) • in-office surgery • allergy testing	**$25** for each visit to your PCP or OB/GYN **$45** for each visit to a specialist
• urgent care visits	**$25** for each visit to your PCP **$45** for each visit to a specialist
• mammograms	**No Charge**
• mental health and substance abuse visits	**$25** for each visit
• allergy serum and allergy injections (if actual cost of serum and injection is less than the copay, member is only charged actual cost)	**$25** for each visit to your PCP **$45** for each visit to a specialist
Routine Vision	
• annual routine eye exam *Administered by Blue View Vision*	**$15** for each visit
Labs, Diagnostic X-rays	
• diagnostic tests • lab work* • diagnostic x-rays (other than advanced diagnostic imaging services) **Provided through LabCorp*	**No Charge**
Maternity Services	
• all routine outpatient pre-and postnatal care (excluding inpatient stays) • diagnostic testing (such as ultrasound, non-stress tests and other fetal monitor procedures)	**$50** per pregnancy **No Charge**
Emergency Care	
• true emergency care visits in or out of the service area **Waived if admitted directly to the hospital.*	**$150** for each visit to an emergency room*
Early Intervention – For children from birth through age 2	
• early intervention services	Member cost shares will be dependent on the services rendered.
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
• diagnosis and treatment of autism spectrum disorder including: • behavioral health treatment* • psychiatric care • therapeutic care** • pharmacy care • psychological care ** Mental Health Services* ***Unlimited physical, occupational and speech therapy.*	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
• nutritional counseling (maximum 5 visits per year)	**$45** benefit payable per visit
• ambulance travel	**No Charge**
• physical, occupational and speech therapy	**$45** for each visit
• spinal manipulation and manual medical therapy services (Limited to 30 visits per plan year) *Administered by American Specialty Group (ASG)*	**$25** for each visit
• infusion therapy • chemotherapy • radiation therapy • dialysis	**No Charge**

All Other Services (subject to deductible)	
You will pay all the costs associated with your care until you have paid $150 per Individual / $150 per Family in one plan year. This is known as your deductible. ***Once you reach your deductible you pay:***	
Inpatient Stays in a Hospital or Facility	
• semi-private room • private room when approved in advance • intensive or coronary care unit • maternity services • mental health and substance abuse services • skilled nursing facility (100 days for each admission) • occupational, speech and physical therapy	**30%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
Other Outpatient Services	
• advanced diagnostic imaging services (includes MRI, MRA, CTA and CT scans) done in an office setting	**10%** after deductible of the amount the health care professionals in our network have agreed to accept for their services.
• advanced diagnostic imaging services (includes MRI, MRA, MRS, CTA, PET scans and CT scans) done in all other settings	**30%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• surgery in a hospital or facility (including bony impacted wisdom teeth extractions)	**30%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• hospice care	**30%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• home health care (Limited to 90 visits per plan year)	**$45** per visit after deductible
• diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered after deductible.
• prosthetic devices	**30%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• durable medical equipment • medical supplies	**No Charge** after deductible
• cardiac rehab therapy	**30%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
• applied behavioral analysis	**30%** of the amount the health care professionals in our network have agreed to accept for their services (after deductible, except for services related to preventive care)

Out-of-Network Services

Deductible for services received from out-of-network health care professionals

You will pay all of the costs associated with covered services until you pay $400 per Individual / $800 per Family in one plan year.

Once you have reached this amount, when you receive covered services you will pay 30% and we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. What you pay includes any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges (this is referred to as balance billing). If you go to an eye care professional not in our Blue View Vision network for your routine eye examination, we will pay $30 (whether or not you have reached the out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using in-network professionals
If you are the only one covered by your plan, you will pay $3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.
- If two people are covered under your plan, each of you will pay $3,000 ($6,000 total).
- If three or more people are covered under your plan, together you will pay $6,000. However, no family member will pay more than $3,000 toward the limit.

When using out-of-network professionals
If you are the only one covered by your plan, you will pay $3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.
- If two people are covered under your plan, each of you will pay $3,000 ($6,000 total).
- If three or more people are covered under your plan, together you will pay $6,000. However, no family member will pay more than $3,000 toward the limit.

The following do not count toward the calendar year out-of-pocket maximum:
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under this plan
- the cost associated with vision services

SPECIALIST VISITS DO NOT REQUIRE PCP REFERRAL.

Some benefits may be subject to balance billing, if provided by a non-participating provider.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Henrico County General Government and Public Schools
Lumenos® HSA Plan Summary

The Lumenos HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. This plan gives you benefits with a high deductible (your upfront out-of-pocket cost) and health care dollars to spend your way.

Your Lumenos HSA Plan	
First - Use your HSA to pay for covered services: **Health Savings Account** With the Lumenos Health Savings Account (HSA), you can **contribute pre-tax dollars to your HSA**. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.	**Contributions to Your HSA*** **The 2015 annual contribution maximum set by the U.S. Treasury and IRS:** $3,350 individual coverage $6,650 family coverage (any dependent coverage) **Henrico's 2015 contribution to your HSA:** $1,200 individual coverage $2,400 family coverage (any dependent coverage) *These limits apply to all combined contributions from any source including dollars you contribute to your HSA and dollars your employer contributes to your HSA. Rollover funds are not subject to these limits.
Plus - To help you stay healthy, use: **Preventive Care** 100% coverage for nationally recommended services.	**Preventive Care** No out-of-pocket costs for you as long as you receive your preventive care from an in-network provider. If you choose to go to an out-of-network provider, your deductible or traditional health coverage benefits will apply.
Then - **Your Deductible** The deductible is the annual amount you pay – using your HSA or out-of-pocket – before you reach the traditional health coverage portion of the plan.	**Annual Deductible Responsibility*** $3,000 individual coverage $6,000 family coverage ($3000 individual level) Your benefit period runs on a calendar year from January 1 through December 31. *The deductible includes both medical services and prescription drugs.
If needed - **Traditional Health Coverage** Similar to a PPO or HMO, after you meet your deductible, you pay coinsurance (a percentage of the provider's charges) or a copay when you visit an in-network provider. You'll pay more if you visit an out-of-network provider. Your traditional health coverage begins: 1) Once any family member reaches the individual level deductible (within the annual deductible), that family member's future expenses will be eligible for traditional health coverage. 2) The remaining family members must satisfy the remainder of the annual deductible before traditional health coverage begins.	**Traditional Health Coverage for Medical Services** After your deductible, the plan pays: 100% for in-network providers — 70% for out-of-network providers **Traditional Health Coverage for Prescription Drugs** After your deductible, your copay responsibility is: In-network pharmacies: Retail: $10/$30/$55 for 30 day supply — same as in-network pharmacies Mail order: $10/$60/$165 for 90-day supply — n/a
Additional protection: For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the **plan pays 100% of the cost for covered services** for the remainder of the plan year with the exception of: routine vision care, the cost of care received when the benefit limits have been reached, the cost of services and supplies not covered under your benefits and balance billed amounts by out of network providers.	**Annual Out-of-Pocket Maximum** In-Network Providers: $4,000 individual coverage; $8,000 family coverage Out-of-network Providers: $6,000 individual coverage; $12,000 family coverage Your annual out-of-pocket maximum consists of your annual deductible and your copay/coinsurance amounts.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Henrico County General Government and Public Schools
Lumenos® HSA Plan Summary

Overview of Covered Preventive Services

Preventive Care

Anthem's Lumenos HSA plan covers preventive services[1] recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to help prevent avoidable premature injury, illness and death.

All preventive services received from a network provider are covered at 100%, are not deducted from your HSA and do not apply to your deductible. If you see an out-of-network provider, then your deductible or out-of-network coinsurance responsibility will apply. If you receive any of these services for diagnostic purposes – for example, a colonoscopy when symptoms are present – the appropriate plan deductible and coinsurance will apply and available account funds may be used to cover costs.

The following is an overview of the types of preventive services covered:

Child Preventive Care

Office Visits for preventive services
Screening Tests for vision, hearing, and lead exposure. Also includes pelvic exam and Pap test for females who are age 18, or have been sexually active.
Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer
- H. Influenza type b
- Polio
- Measles, Mumps, Rubella (MMR)

Adult Preventive Care

Office Visits for preventive services
Screening Tests for coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams and Pap test.
Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer

Summary of Exclusions or Limitations

Some covered services may have limitations or other restrictions.[2] With Anthem's Lumenos HSA plan, the following services are limited:

Annual routine vision exam $15; not subject to deductible.
Skilled nursing facility services limited to 100 days per benefit period.
Home health care services limited to 100 visits per benefit period.
Physical and occupational therapy services limited to a combined 30 visits per benefit period.[3]
Speech therapy services limited to 30 visits per benefit period.[3]
Spinal manipulations and other manual medical intervention visits limited to 30 visits per benefit period.
Early intervention services unlimited per member per calendar year from birth through age 2.
Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder is unlimited per member per benefit period for age two through age six.
Wigs limited to 1 wig per member per year.

1 Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
2 Additional limitations and exclusions may apply. For a complete list of exclusions and limitations, please refer to your Evidence of Coverage. Some covered services may require pre-approval.
3 Speech, physical and occupational therapies are unlimited for Early Intervention and Autism Spectrum Disorder.

Please note: This summary is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Group Contract, Evidence of Coverage and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail. This summary is for a full year in the Lumenos plan. If you join the plan mid-year or have a qualified change of status, your actual benefit levels may vary. The information included does not constitute legal, tax, or benefit plan design advice. Anthem strongly encourages consultation with a tax advisor before establishing a Health Savings Account. Any Health Savings Account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.

Henrico County General Government and Public Schools
Anthem KeyCare PPO Plan

Covered Services (not subject to deductible)	IN-NETWORK You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which may result in a member cost share.	***No Charge**
Outpatient Services	
• mammograms	**No Charge**
• maternity services for all routine outpatient pre-and postnatal care (excluding inpatient stays)	**$50** copay
• nutritional counseling (maximum 5 visits per year)	**$45** benefit payable per visit
Routine Vision	
• annual routine eye exam *Administered by Blue View Vision*	**$15** for each visit
All Other Services (subject to deductible)	
You will pay all the costs associated with your care until you have paid $400 per Individual / $800 per Family in one plan year. This is known as your deductible. Once you reach your deductible you pay:	
Doctor Visits	
• office visits • urgent care visits • wisdom teeth extractions (bony impacted only) • in-office surgery • voluntary family planning • allergy testing	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• allergy serum and allergy injections (if actual cost of serum and injection is less than the Allowable Charge, member is only charged actual cost)	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
Labs, Diagnostic X-rays	
• diagnostic tests • diagnostic x-rays • lab work	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• advanced diagnostic imaging services (includes MRI, MRA, MRS, CTA, PET scans and CT scans)	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
Emergency Care	
• true emergency care visits in or out of the service area	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth through age 2	
• early intervention services	Member cost shares will be dependent on the services rendered after deductible.

Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
• diagnosis and treatment of autism spectrum disorder including: • behavioral health treatment* • pharmacy care • psychiatric care • psychological care • therapeutic care** **** Mental Health Services*** *****Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered after deductible.
• applied behavioral analysis	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after deductible, except for services related to preventive care)
Other Outpatient Services	
• ambulance travel	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• physical, occupational and speech therapy • spinal manipulation and manual medical therapy services *(Limited to 30 visits per plan year)*	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• infusion therapy • chemotherapy • radiation therapy • dialysis • cardiac rehab therapy	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• surgery in a hospital or facility (including bony impacted wisdom teeth extractions)	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• hospice care • home health care *(Limited to 90 visits per plan year)*	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
• durable medical equipment • medical supplies	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• prosthetic devices	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• mental health and substance abuse visits	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services

Inpatient Stays in a Hospital or Facility	
• semi-private room • private room when approved in advance • intensive or coronary care unit • maternity services • mental health and substance abuse services • occupational, speech and physical therapy • skilled nursing facility (100 days for each admission)	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $1,000 in one calendar or plan year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $1,000 of the cost of your care ($2,000 total).
- If three or more people are covered under your plan, together you will pay the first $2,000 of the cost of your care. However, the most one family member will pay is $1,000.

Once you have reached this amount, when you receive covered services you will pay 30% and we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. What you pay includes any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges (this is referred to as balance billing). If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $1,000 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using in-plan professionals
If you are the only one covered by your plan, you will pay $3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.
- If two people are covered under your plan, each of you will pay $3,000 ($6,000 total).
- If three or more people are covered under your plan, together you will pay $6,000. However, no family member will pay more than $3,000 toward the limit.

When not using out-of-plan professionals
If you are the only one covered by your plan, you will pay $3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay $3,000 ($6,000 total).
- If three or more people are covered under your plan, together you will pay $6,000. However, no family member will pay more than $3,000 toward the limit.

When using in-plan professionals and out-of-plan professionals
The amounts referenced above for in-plan and out-of-plan professionals do not cross accumulate. Therefore, you are responsible for the separate amounts for in-plan and out-of-plan based on the providers you are using.

The following do not count toward the calendar year out-of-pocket maximum. You will still need to pay:
- the costs associated with vision benefits
- the cost of care received when the benefit limits have been reached

Some benefits may be subject to balance billing, if provided by a non-participating provider.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Prescription Drug Schedule of Benefits

PRESCRIPTION DRUGS *	PARTICIPANT PAYS
	Participating Pharmacies must be used
First-tier Drugs	
Copayment for 30-day supply (Retail Pharmacy)	$ 10
Copayment for 90-day supply (Home Delivery)	$ 10
Second-tier Drugs	
Copayment for 30-day supply (Retail Pharmacy)	$ 30
Copayment for 90-day supply (Home Delivery)	$ 60
Third-tier Drugs	
Copayment for 30-day supply (Retail Pharmacy)	$ 55
Copayment for 90-day supply (Home Delivery)	$165

***Note**: On the Lumenos HSA plan, you must meet the annual deductible before the prescription drug copayments apply.

Also see Section 9 for additional benefit information.

Vision Schedule of Benefits

VISION	In-Network	Out-of-Network	Benefit Maximum
Routine Eye Exam			Once every calendar year
Copayment per visit	$15	N/A	
Benefit Payable	100%	$30 allowance	
Retinal Imaging (at member's option)	Discount up to $39	N/A	
Standard Contact Lens Fitting	Covered in full	N/A	
Copayment	100%	$35 allowance	
Benefit Payable			
Premium Contact Lens Fitting	N/A	N/A	
Copayment	10% off retail, then	$35 allowance	
Benefit Payable	apply $55 allowance		

Also see Section 10 for additional benefit information.

SECTION 8
MEDICAL BENEFITS

A participant's health plan covers only those medical services that are Medically Necessary. Just because the service is prescribed by a Provider does not mean the service is Medically Necessary. In addition, a participant's health plan requires that services be safely performed in the least costly Setting.

See the **Schedule of Benefits** (Section 7) for payment levels and limits for the Covered Services.
All of the following services, except as noted, must be rendered by covered facilities or Providers.

Ambulance service
Medically necessary ambulance services are a covered service when one or more of the following criteria are met:

- A participant is transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, the participant is taken:
    - From his home, the scene of an accident or medical emergency to a hospital;
    - Between hospitals, including when the Claims Administrator requires him to move from an out-of-network hospital to an in-network hospital;
    - Between a hospital and a skilled nursing facility or other approved facility.
- For air or water ambulance, a participant is taken:
    - From the scene of an accident or medical emergency to a hospital;
    - Between hospitals, including when the Claims Administrator requires him to move from an out-of-network hospital to an in-network hospital;
    - Between a hospital and an approved facility.

Ambulance services are subject to medical necessity reviews by the Claims Administrator. When using an air ambulance for non-emergency transport, the Claims Administrator reserves the right to select the air ambulance provider. If a participant does not use the air ambulance provider selected by the Claims Administrator, the out-of-network provider may bill the participant for any charges that exceed the plan's maximum allowed amount.

A participant must be taken to the nearest facility that can give care for his condition. In certain cases, the Claims Administrator may approve benefits for transportation to a facility that is not the nearest facility.

Benefits also include medically necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if a participant is not taken to a facility.

Important Notes on Air Ambulance Benefits: Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger a participant's health and his medical condition requires a more rapid transport to a facility than the ground ambulance can provide, the plan will cover the air ambulance.

Air ambulance will also be covered if a participant is in an area that a ground or water ambulance cannot reach. Air ambulance will not be covered if a participant is taken to a hospital that is not an acute care hospital (such as a skilled nursing facility), or if he is taken to a physician's office or his home.

Hospital to Hospital Transport: If a participant is moving from one hospital to another, air ambulance will only be covered if using a ground ambulance would endanger his health and if the hospital that first treats cannot give him the medical services he needs. Certain specialized services are not available at all hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain hospitals. To be covered, a participant must be taken to the closest hospital that can treat him. Coverage is not available for air ambulance transfers simply because the participant, his family, or his provider prefers a specific hospital or physician.

Autism services

A participant's health plan covers certain treatments associated with autism spectrum disorder (ASD) for Dependents from age two through age six. Coverage for ASD includes but is not limited to the following:

- diagnosis of autism spectrum disorder;
- treatment of autism spectrum disorder;
- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

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

Clinical trial cost

A participant's coverage includes benefits for clinical trial costs. Clinical trial costs means patient costs incurred during participation in a clinical trial when such trial is conducted to study the effectiveness of a particular treatment of cancer. The criteria for these costs is found in Exhibit A.

Dental services (All participants/all ages)

The Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Benefits are also available for dental work needed to treat injuries to the jaw, teeth, mouth, or face as a result of an accident. An injury that results from chewing or biting is not considered an accidental injury under this plan, unless the chewing or biting results from a medical or mental condition. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth, or face are also covered.

The Plan includes coverage of general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care.

The Plan provides coverage only for functional repairs. Services of a cosmetic nature, or not deemed to be functional by the Claims Administrator, are not a covered service.

Diabetic supplies, equipment, and education

The health plan covers medical supplies, equipment, and education for diabetes care for all diabetics.

This includes coverage for the following:

- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles and syringes when purchased from a network pharmacy; and
- Outpatient self-management training and education performed in-person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

Screenings for gestational diabetes are covered under Wellness services.

Diagnostic tests

A participant's benefits include coverage for the following procedures when ordered by his doctor to diagnose a definite condition or disease because of specific signs and/or symptoms:

- radiology (including mammograms), ultrasound or nuclear medicine;
- laboratory and pathology services or tests;
- diagnostic EKGs, EEGs; and
- advanced diagnostic imaging services (includes magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), magnetic resonance spectroscopy (MRS), positron emission tomography (PET) scan, computed tomography (CT) scan, and computed tomographic angiography (CTA).

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital Stay is covered under a participant's health plan only when:

- his medical condition requires that medical skills be constantly available;
- his medical condition requires that medical supervision by his doctor is constantly available; or
- diagnostic services and equipment are available only as an Inpatient.

Medical supplies and other services that may be required and provided in conjunction with a diagnostic test are not considered part of the diagnostic test. Therefore, if a facility or Provider bills a separate charge for such services or supplies, benefits for such services or supplies will be provided as described in the Schedule of Benefits for such services and supplies and not as part of the diagnostic test.

Dialysis
A participant's health plan covers dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

Doctor Visits and services
The health plan covers:

- Visits to a doctor's office or doctor's visits to a participant's home;
- Visits to an Urgent Care center;
- Visits to a hospital Outpatient department or emergency room;
- Visits for shots needed for treatment (for example, allergy shots);
- Online Visits (such Visits do not include reporting normal lab or other test results, requesting office Visits, getting answers to billing, coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or doctor to doctor discussions); and
- Interactive telemedicine services

Early intervention services
The health plan covers early intervention services for covered Dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible
for services under Part C of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be Medically Necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for listed services shall not be denied on the ground that they are not Medically Necessary.

Emergency room care
The health plan covers emergency room Visits, services, and supplies necessary for the treatment of an emergency as defined in Section 2. If a participant is admitted to the hospital from the emergency room, the hospital Stays must be reviewed by the Claims Administrator within 48 hours of admission. The

emergency room doctor, a relative, or a friend can call the Claims Administrator for Hospital Admission Review in an emergency.

Home care services
The health plan covers treatment provided in a participant's home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat a participant's condition. To ensure benefits, a participant's doctor must provide a description of the treatment he will receive at home. A participant's coverage includes the following home health services:

- Visits by a licensed health care professional, including a nurse, therapist, or home health aide; and
- Physical, speech, and occupational therapy (services provided as part of home health are not subject to separate Visit limits for therapy services).

These services are only covered when a participant's condition generally confines him to his home except for brief absences.

Home private duty nurse's services
If a participant is enrolled in the PPO plan, his health plan covers the cost of medically skilled services of a currently licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in his home when the nurse is not a relative or member of his family. A participant's doctor must certify to the Plan that private duty nursing services are Medically Necessary for his condition, and not merely custodial in nature.

If a participant is enrolled in the POS plan or the Lumenos HSA plan, these services are NOT covered.

Hospice care services
Hospice care will be covered, for Covered Persons diagnosed with a terminal illness with a life expectancy of six months or less. Covered Services include the following:

- skilled nursing care, including IV therapy services;
- drugs and other Outpatient prescription medications for palliative care and pain management;
- services of a medical social worker;
- services of a home health aide or homemaker;
- short-term Inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute Inpatient care for the Covered Person in order to provide the Covered Person's primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided for more than five days every 90 days;
- physical, speech, or occupational therapy (services provided as part of hospice care are not subject to separate Visit limits for therapy services);
- Medical Equipment (Durable);
- routine medical supplies;
- routine lab services;
- counseling, including nutritional counseling with respect to the Covered Person's care and death; and
- bereavement counseling for immediate family members both before and after the Covered Person's death.

Hospital services
The health plan covers the hospital and doctors' services when the participant is treated on an Outpatient basis, or when he is an Inpatient because of illness, injury, or pregnancy. (See Maternity later in this section for an additional discussion of pregnancy benefits.) The health plan covers Medically Necessary care in a semi-private room or intensive or special care unit. This includes his bed, meals, special diets, and general nursing services.

In addition to a participant's semi-private room, general nursing services, and meals, the health plan covers the Maximum Allowed Amounts for Medically Necessary services and supplies furnished by the hospital when prescribed by a participant's doctor or Provider.

Hospitals in the KeyCare PPO Network must meet the American Hospital Association's standards for registration as a hospital.

While a participant is an Inpatient in the hospital, the health plan covers the Medically Necessary services rendered by doctors and other covered Providers.

All non-emergency inpatient hospital stays must be approved in advance, except hospital stays for vaginal or cesarean deliveries without complications.

Infusion services
When authorized by the Claims Administrator, the health plan covers infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

Injectable medications
The coverage includes benefits for self-administered injectable medications obtained through a retail pharmacy or administered by a network Provider.

Lymphedema
A participant's coverage includes benefits for expenses incurred in connection with the treatment of lymphedema.

Maternity
Prenatal and newborn care
If a participant (or his covered Dependent) becomes pregnant, the health plan provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered by the health plan.

A participant's benefits include:
- use of the delivery room and care for normal deliveries;
- home setting covered with nurse midwives;
- Home care services for postnatal care;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- hospital services for routine nursery care for the newborn during the mother's normal hospital Stay;
- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- initial examination of a newborn and circumcision of a covered male Dependent;
- services for interruption of pregnancy; and
- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

Medical equipment (Durable)
The health plan will cover the rental (or purchase if that would be less expensive) of Medical Equipment (Durable) when prescribed by a participant's doctor (and when obtained from a HealthKeepers durable equipment provider if enrolled in the POS or Lumenos HSA plan). Also covered are maintenance and necessary repairs of Medical Equipment (Durable) except when damage is due to neglect.

Coverage includes the following types of equipment:
- nebulizers;
- hospital type beds;

- wheelchairs;
- traction equipment;
- walkers; and
- crutches.

Medical devices and appliances
The health plan covers the cost of fitting, adjustment, and repair of the following items when prescribed by a participant's doctor for Activities of Daily Living (examples include):

- orthopedic braces;
- leg braces, including attached or built-up shoes attached to the leg brace;
- molded, therapeutic shoes for diabetics with peripheral vascular disease;
- arm braces, back braces, and neck braces;
- head halters;
- catheters and related supplies;
- orthotics, other than foot orthotics; and
- splints.

Medical formulas
The health plan covers special medical formulas which are the primary source of nutrition for Covered Persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

Medical supplies and medications
A participant's coverage includes benefits for medical supplies and medications. Examples of medical supplies include:

- hypodermic needles and syringes;
- allergy serum;
- oxygen and equipment (respirators) for its administration; and
- non-injectable prescription medications provided by a participant's doctor.

Medication management
Visits to a participant's physician to make sure that medication he is taking for a mental health or substance abuse problem is working and the dosage is right for him are covered.

Mental health or substance use disorder treatment
Accessing mental health services and substance use disorder services (treatment of alcohol or drug dependency) is easy. In fact, participants have a dedicated department available to them. Refer to Section 20 for the phone number. All participants can select any mental health and substance use Provider listed in the Provider directory. If a participant is unsure of which Provider to see, he may call the Mental Health Services phone number (provided in Section 20), and the representative will be able to match the participant with a Provider who seems best suited to meet the participant's needs.

Covered services include the following:

- **Inpatient services**
  Inpatient services in a hospital or any facility that the plan must cover per state law. Inpatient benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, electroconvulsive therapy, detoxification, and rehabilitation.

- **Outpatient services**
  Office Visits and treatment in an outpatient department of a hospital or outpatient facility, such as partial hospitalization programs and intensive outpatient programs. Covered services include individual psychotherapy, group psychotherapy, psychological testing and medication management Visits (Visits to a participant's physician to make sure that the medication he is taking

for a mental health or substance use disorder is working and the dosage is right for the participant).

- **Residential treatment**
  Treatment which is specialized 24-hour treatment in a licensed residential treatment center or intermediate care facility. It offers individualized and intensive treatment and includes:

  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation, therapy, and education.

Participants can get covered services from the following providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C.) or
- Any agency licensed by the state to give services, when the plan has to cover them by law.

Organ and tissue transplants, transfusions
The health plan covers organ and tissue transplants and transfusions. When a covered human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive the benefits of the health plan.

Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of Experimental/Investigative services.

Private room
The health plan will cover a stay in a semi-private room unless a private room is approved in advance by the Claims Administrator. The health plan will cover the private room charge if a participant needs a private room because he has a highly contagious condition or is at greater risk of contracting an infectious disease because of his medical condition. Otherwise, a participant's Inpatient benefits would cover the hospital's charges for a semi-private room. If the participant chooses to occupy a private room, he will be responsible for paying the daily differences between the semi-private and private room rates in addition to the Copayment and Coinsurance (if any).

Prosthetic devices and components
A participant's coverage includes benefits for prosthetic devices. A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot, or eye. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

Shots (Injections)
The health plan covers therapeutic injections (shots) that a Provider gives to treat illness (*e.g.*, allergy shots) or pregnancy-related conditions. Also included is allergy serum for allergy shots. In addition, a participant has coverage for immunizations and self-administered injections.

Skilled Nursing Facility Stays
A participant's coverage includes benefits for Skilled Nursing Facility Stays. Coverage for a Stay requires prior approval. The participant's doctor must submit a plan of treatment that describes the type of care he needs.

The following items and services will be provided to him as an Inpatient in a skilled nursing bed of a Skilled Nursing Facility:

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the Skilled Nursing Facility and other Medically Necessary services and supplies.

The health plan will cover the private room charge if a participant needs a private room because he has a highly contagious condition or is at greater risk of contracting an infectious disease because of his medical condition. Otherwise, his Inpatient benefits would cover the Skilled Nursing Facility's charges for a semi- private room. If he chooses to occupy a private room, he will be responsible for paying the daily difference between the semi-private and private room rates in addition to his Copayment and Coinsurance (if any).

Custodial or residential care in a Skilled Nursing Facility or any other facility is not covered except as rendered as part of hospice care.

Spinal manipulation and other manual medical interventions
If a participant is enrolled in the PPO, his health plan covers spinal manipulation services (manual medical interventions) and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations such as massage and myofascial release.

If a participant is enrolled in the POS or Lumenos HSA plan*,* his coverage includes spinal manipulation and manual medical therapy services when performed by a Provider within the American Specialty Health Group ("ASGH").Covered Services include examination, re-examination, manipulation, conjunctive therapy, radiology, Durable Medical Equipment, and laboratory tests related to the delivery of these services.

To receive care, please Visit the website at www.anthem.com, or contact ASHG directly for a list of ASHG Providers. Then, simply contact a participating ASHG Provider to make an appointment. The ASHG Provider is responsible for obtaining authorization prior to providing care.

Questions concerning ASHG Providers may be directed to ASHG's network department at 800-972-4226.. Questions concerning coverage may be directed to ASHG's customer service department 800-678-9133.

In addition, certain other types of skeletal adjustments or manual manipulations performed by osteopaths may be covered when approved through the advance approval process as described in Section 6. These services may be performed by Providers outside the ASHN network when approval is received.

Surgery

General surgery
Surgery charges are covered when treatment is received at an Inpatient, Outpatient or ambulatory surgery facility, or doctor's office. The health plan will not pay separately for pre- and post-operative services.

Reconstructive breast surgery and mastectomy
Mastectomy, or the surgical removal of all or part of the breast, is a Covered Service. Also covered are:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Covered Person.

Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts is also covered.

Oral surgery
If a participant is enrolled in the PPO, his health plan covers oral surgery for:

- surgical removal of impacted wisdom teeth;
- maxillary or mandibular frenectomy when not related to a dental procedure;
- alveolectomy when related to tooth extraction;
- orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
- surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; and
- the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

If a participant is enrolled in the POS or Lumenos HSA, his health plan covers oral surgery for:

- extraction of either erupted or impacted wisdom teeth;
- surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth or their supporting structures;
- treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
- orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed *Medically Necessary* to attain functional capacity of the affected part.

Therapy
The health plan covers the following therapies when the treatment is medically necessary for a participant's condition and provided by a licensed therapist. If he is enrolled in the POS or Lumenos HSA plan, short-term rehabilitative therapy services for physical, occupational, or speech therapy can be expected to result in significant improvement of his condition within 90 consecutive days of beginning Outpatient treatment. Refer to the Schedule of Benefits for limitations, Copayment and Coinsurance amounts.

- **Cardiac rehabilitation therapy**
  The health plan includes benefits for cardiac rehabilitation which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

- **Chemotherapy**
  The health plan covers the treatment of disease by chemical or biological antineoplastic agents.

- **Occupational therapy**
  The health plan covers occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities of daily living, such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.

- **Physical therapy**
  The health plan covers physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. A participant's coverage includes benefits for physical therapy to treat lymphedema.

- **Radiation therapy**
  The health plan covers radiation therapy, including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

- **Respiratory therapy**
  The health plan covers respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

- **Speech therapy**
  The health plan covers speech therapy, which is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.

Vision correction after surgery or accident
The health plan covers the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations:
- contact lenses are used for the treatment of infantile glaucoma;
- corneal or scleral lenses are prescribed in connection with keratoconus;
- scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
- corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

Wellness services
The health plan covers preventive care services for children, adolescents and adults. Preventive care services generally include check-up Visits, developmental assessment and guidance, screening tests, intervention counseling/education services, immunizations and other services to prevent the development of disease or allow the detection of medical conditions in advance.

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

Additionally, a routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and a participant's Provider performs additional necessary Covered Services, these services will generally be covered as diagnostic and/or surgical services and not as preventive care services. Also, covered screenings that a participant undergoes because he has a personal or family history of a particular condition are not generally covered as preventive care services. Deductibles, Copayments and Coinsurance amounts applicable to diagnostic and/or surgical services may be different from those applicable to preventive care services. Please see the Diagnostic tests and Surgery sections in the **Schedule of Benefits** for more information.

The preventive care services in this section meet the requirements outlined under federal and state law. Preventive care services covered by a participant's health plan that meet these requirements are not subject to cost shares (for example, Deductible, Copayment, and/or Coinsurance amounts) when services are received from in-network Providers. That means the Claims Administrator pays 100% of the Maximum Allowed Amount. Cost shares will apply when services are received from Out-of-Network

Providers. 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:

- breast cancer;
- cervical cancer;
- colorectal cancer;
- high blood pressure;
- type 2 diabetes mellitus;
- cholesterol;
- child and adult obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

    - women's contraceptives, including all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and counseling. Contraceptive coverage includes generic and single-source brand drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra-uterine devices (IUDs), and implants are also covered. Standard multi-source brand drugs will be covered under the prescription drug benefit;
    - breast feeding support, supplies, and counseling. Standard benefits for breast pumps are limited to one pump per pregnancy;
    - gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes;
    - testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of pap smear results;
    - annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women;
    - screening and counseling for interpersonal and domestic violence;
    - well woman Visits.

5. Counseling services related to general nutrition, and to smoking and tobacco use cessation.

Plan participants may call Member Services for additional information about these services. Participants may also visit the federal government websites:

- http://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov; or
- http://www.cdc.gov/vaccines/acip/index.html

In addition to the Federal requirements above, preventive coverage also includes the following covered services at intervals no less frequent than as required by state law:

- Routine screening mammograms;
- Routine annual Pap tests including coverage for testing performed by any FDA-approved gynecologic cytology screening technologies;
- Routine annual prostate specific antigen testing and digital rectal exams for male enrollees age 40 and older.

SECTION 9
PRESCRIPTION DRUG BENEFITS

Prescription drug benefit at a retail or home delivery (mail order) pharmacy

The health plan includes benefits for prescription drugs a participant gets at a retail or mail order pharmacy. The Claims Administrator uses a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of retail pharmacies, a home delivery (mail order) pharmacy, and a specialty pharmacy. The PBM works to make sure drugs are used properly. This includes checking that prescriptions are based on recognized and appropriate doses and checking the drug interactions or pregnancy concerns.

Note: Benefits for prescription drugs, including specialty drugs, which are administered to participants in a medical setting (doctor's office, home care Visit, or outpatient facility) are covered under the "Prescription drugs administered by a medical provider" benefit.

Prescription drug benefits
As described in the "Prescription drugs administered by a medical provider" section, prescription drug benefits may depend on reviews to decide when drugs should be covered. These reviews may include prior authorization, step therapy, use of a prescription drug list, therapeutic substitution, day/supply limits, and other utilization services. In-network pharmacists will be told of any rules when a participant fills a prescription, and will be also told about any details the Claims Administrator needs to decide benefits.

Covered prescription drugs
To be a covered service, prescription drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a prescription. Prescription drugs must be prescribed by a licensed provider and the participant must get them from a licensed pharmacy.

Benefits are available for the following:

- prescription legend drugs from either a retail pharmacy or the PBM's home delivery pharmacy;
- specialty drugs;
- self-administered injectable drugs. These are drugs that do not need administration or monitoring by a provider in an office or facility. Office-based injectables and infused drugs that need provider administration and/or supervision are covered under the "Prescription drugs administered by medical provider" benefit;
- oral chemotherapy drugs when administration or monitoring by a provider or in an office or facility is not required;
- self-injectable insulin and supplies and equipment used to administer insulin;
- self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive care" benefit.
- special food products or supplements when prescribed by a doctor if the Claims Administrator agrees they are Medically Necessary;
- flu shots (including administration). These will be covered under the preventive care benefit.

In addition, a participant's coverage includes prescription and over-the-counter (OTC) drugs used to assist with smoking cessation at either the Tier 1 (generic) copay or Tier 3 (brand) copay provided the participant obtains a prescription from his physician.

Covered over-the-counter (OTC) nicotine replacement products include (30-day max supply at retail pharmacies only):

- Nicotine patch (generic equivalents of NicoDermCQ®). Generic tier 1; Brand tier 3
- Nicotine gum (generic equivalents of Nicorette®). Generic tier 1; Brand tier 3
- Nicotine lozenges (generic equivalents of Commit®). Generic tier 1; Brand tier 3

Prescription smoking cessation coverage includes a 30-day max supply at retail pharmacies and 90-day max supply through Express Scripts home delivery. If your physician requires that a participant take the brand name drug instead of the generic drug, it will be covered at the applicable copayment. However, if a participant elects the brand name drug when a generic is available, he will pay his usual copayment for the generic drug plus the difference in the maximum allowed amount between the generic and brand prescription smoking cessation medications listed below:

- Buproban (tier 1)
- Bupropion (tier 1)
- Chantix (tier 3)
- Nicotrol Inhaler & Nasal Spray (tier 3)

The plan also covers select over-the-counter (OTC) drugs at the Tier 1 copay, provided a participant obtains a prescription from his physician. A 30-day supply is available per prescription at local participating retail pharmacies only.

Covered OTC medications include:

- Lansoprazole (generic equivalents of Prevacid OTC®)
- Omeprazole (generic equivalents of Prilosec OTC®/Zegerid OTC™)
- Cetirizine (generic equivalents of Zyrtec OTC®)
- Cexofenadine (generic equivalents of Allegra OTC®)
- Loratadine (generic equivalents of Claritin OTC®/Alavert OTC®)
- Alaway™
- Zaditor®
- Miralax OTC®

The Claims Administrator cannot deny prescription drugs (or inpatient or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Additionally, benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been described, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Refer to Exhibit A Experimental/Investigative Criteria for additional information about the exception criteria and requirements for these coverage situations.

Where participants can get prescription drugs

In-network pharmacy
Participants can visit one of the local retail pharmacies in the Claims Administrator's network. The participant can give the pharmacy the prescription from his doctor and his Identification Card, and they will file the claim for him. The participant will need to pay any copayment, coinsurance, and/or deductible that applies when he gets the drug. If he does not have his Identification Card, the

pharmacy will charge him the full retail price of the prescription and will not be able file the claim. The participant will need to ask the pharmacy for a detailed receipt and send it to the Claims Administrator with a written request for payment.

Specialty pharmacy
If a participant needs a specialty drug, he or his doctor should order it from the PBM's specialty pharmacy. The Claims Administrator keeps a list of specialty drugs that may be covered based upon clinical findings from the pharmacy and therapeutics (P&T) process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's specialty pharmacy has dedicated patient care coordinators to help a participant take charge of his health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer a participant's questions about specialty drugs.

When a participant uses the PBM's specialty pharmacy a patient care coordinator will work with the participant and his doctor to get prior authorization and to ship his specialty drugs to him or his doctor's office. A participant's patient care coordinator will also tell him when it is time to refill his prescription.

Participants can get a list of covered specialty drugs by calling Member Services at the phone number on the back of his Identification card or by checking the Claims Administrator's website at www.anthem.com.

Home delivery pharmacy
The PBM also has a home delivery pharmacy which lets participants get certain drugs by mail if they take them on a regular basis. Participants will need to contact the PBM to sign up when they first use the service. Participants can mail written prescriptions from their doctor or have their doctor send the prescription to the home delivery pharmacy. A participant's doctor may also call the home delivery pharmacy. Participants will need to send in any copayments, deductible, or coinsurance amounts that apply when they ask for a prescription or refill.

A maintenance medication is a drug one takes on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If a participant is not sure if the prescription drug he is taking is a maintenance medication, he may call Member Services at the number on the back of his Identification Card or check the Claims Administrator's website at www.anthem.com for more details.

Out-of-network pharmacy
Participants may also use a pharmacy that is not in the Claims Administrator's network. The participant will be charged the full price of the drug and he will have to send his claim for the drug to the Claims Administrator (out-of-network pharmacies will not file the claim for the participant). Participants can get a claims form from the Claims Administrator or PBM.

The participant must pay the full retail price of the drug. Reimbursement to him is based on the maximum allowed amount as determined by the Claims Administrator's normal or average contracted rate with network pharmacies on or near the date of service.

Services of non-participating pharmacies
Notwithstanding any provision in this plan document, participants have coverage for outpatient prescription drug services provided to them by an out-of-network pharmacy that has previously notified the PBM of its agreement to accept reimbursement for its services at rates applicable to in-network pharmacies including any applicable copayment, coinsurance, and/or deductible (if any) amounts as payment in full to the same extent as coverage for outpatient prescription drug services provided to the participant by an in-network provider. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating pharmacy agreement with the PBM or its designee within thirty days of being requested to do so in writing by the PBM, unless and until the pharmacy executes and delivers the agreement.

What a participant pays for prescription drugs

Tiers
A participant's share of the cost for prescription drugs may vary based on the tier the drug is in.

- Tier 1 drugs have the lowest coinsurance or copayment. This tier contains low cost and preferred drugs that may be generic, single source brand drugs, or multi-source brand drugs.
- Tier 2 drugs have a higher coinsurance or copayment that those in Tier 1. This tier contains preferred drugs that may be generic, single source, or multi-source brand drugs.
- Tier 3 drugs have a higher coinsurance or copayment than those in Tier 2. This tier contains non-preferred and high cost drugs. This includes drugs considered generic, single source brands, and multi-source brands.

The Claims Administrator assigns drugs to tiers based on clinical findings from the pharmacy and therapeutics (P&T) process. The Claims Administrator retains the right, at its discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). The Claims Administrator may cover one form of administration instead of another, or put other forms of administration in a different tier. The Claims Administrator will provide at least 30-day prior written notice of any modification to a formulary that results in the movement of a prescription drug to a tier with higher cost-sharing requirements.

Prescription drug list
The Claims Administrator also has an Anthem Prescription Drug List (a formulary), which is a list of FDA-approved drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain drugs if they are not on the Prescription Drug List.

The drug list is developed by the Claims Administrator based upon clinical findings, and where proper, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, generic drugs, the use of one drug over another by the Claims Administrator's members, and where proper, certain clinical economic reasons.

The Claims Administrator retains the right, at its discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

There are two exceptions to the formulary requirement:

- Participants may obtain coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if the Claims Administrator determines, after consultation with the prescribing physician, that the formulary drugs are inappropriate for a participant's condition.
- Participants may obtain coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if:
    - A participant has been taking or using the non-formulary prescription drug for at least six months prior to its exclusion from the formulary; and
    - The prescribing physician determines that either the formulary drugs are inappropriate therapy for a participant's condition, or that changing drug therapy presents a significant health risk.

Prescription drugs administered by a medical provider
The health plan also includes prescription drugs when they are administered to a participant as part of a doctor's Visit, home care Visit, or at an outpatient facility. This includes drugs for infusion therapy, chemotherapy, specialty drugs, blood products, and office-based injectables that must be administered by a provider. This section applies when a participant's provider orders the drug and administers it to the participant.

Benefits for drugs that a participant injects or gets at a pharmacy (i.e., self-administered injectable drugs) are not covered under this section. Benefits for those drugs are described in the "Prescription drug benefit at retail or home delivery (mail order) pharmacy" section (above).

Note: When prescription drugs are covered under this benefit, they will not also be covered under the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" benefit. Also, if prescription drugs are covered under the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" benefit, they will not be covered under this benefit.

Important details about prescription drug coverage

The plan includes certain features to determine when prescription drugs should be covered, which are described below. As part of these features, a participant's prescribing doctor may be asked to give more details before the Claims Administrator can decide if the drug is Medically Necessary. The Claims Administrator may also set quantity and/or age limits for specific prescription drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or pharmacy and therapeutics process.

Prior authorization
Prior authorization may be needed for certain prescription drugs to make sure proper use and guidelines for prescription drug coverage are followed. The Claims Administrator will contact a participant's provider to get the details needed to decide if prior authorization should be given. The Claims Administrator will give the results of its decision to both the participant and his provider.

If prior authorization is denied, a participant has the right to file an appeal outlined in the Claims and Payments Section of this plan document.

For a list of drugs that need prior authorization, participants may call the number on the back of their Identification Card. This list will be reviewed and updated from time to time. Including a drug or related item on the list does not promise coverage under the plan. A participant's provider may check with the Claims Administrator to verify drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic drugs are covered under the plan.

Step therapy
Step therapy is a process in which a participant may need to use one type of drug before the Claims Administrator will cover another. The Claims Administrator checks certain prescription drugs to make sure that proper prescribing guidelines are followed. These guidelines help participants get high quality and cost effective prescription drugs. If a doctor decides that a certain drug is needed, prior authorizations will apply.

Therapeutic substitution
Therapeutic substitution is an optional program that tells the participant and his doctors about alternatives to certain prescribed drugs. The Claims Administrator may contact the participant and his doctor to make the participant aware of these choices. Only the participant and his doctor can determine if the therapeutic substitute is right for the participant. The Claims Administrator has a therapeutic drug substitutes list, which they review and update from time to time. For questions or issues about therapeutic drug substitutes, participants may call Member Services at the phone number on the back of their Identification Card.

Additional features of your prescription drug pharmacy benefit

Day supply and refill limits
Certain day supply limits apply to prescription drugs as listed in the Schedules of Benefits. In most cases, a participant must use a certain amount of his prescription before it can be refilled. In some cases the Claims Administrator may let a participant get an early refill. For example, if it is decided that a participant needs a larger dose. The Claims Administrator will work with the pharmacy to decide when this should happen.

If a participant is going on vacation and needs more than the day supply allowed, he should ask his pharmacist to call the Claims Administrator's PBM and ask for an override for one early refill. If the participant needs more than one early refill, he may call Member Services at the number on the back of his Identification Card.

Half-tablet program
The half-tablet program lets participants pay a reduced copayment on selected "once daily dosage" drugs on the Claims Administrator's approved list. The program lets participants get a 30-day supply (15 tablets) of the higher strength drug when the doctor tells them to take a "1/2 tablet daily." The half-tablet program is strictly voluntary and participants should talk to their doctors about the choice when it is available. To get a list of the drugs in the program, participants may call the number on the back of their Identification Card.

Special programs
From time to time the Claims Administrator may offer programs to support the use of more cost-effective or clinically effective prescription drugs including generic drugs, home delivery drugs, over-the-counter drugs or preferred products. Such programs may reduce or waive copayments or coinsurance for a limited time.

SECTION 10
VISION BENEFITS

This section describes coverage for services for routine vision care. Coverage for diseases and Injuries of the eye are described in Section 8 of this Plan Document.

The vision care plan provides vision care services within a special network of vision care Providers. Participants will receive benefits based on where they receive vision care services and the limits stated in the Schedule of Benefits (see Section 7) and related exclusions. This section of the Plan Document details how to access and make the most of the vision care benefits.

Carry the ID card
A participant's coverage ID card identifies him as a member. When a participant shows his ID card to his vision care Providers, they will file claims for the participant in most cases. Carrying the ID card at all times will ensure that participants always have this member information with them when they need it.

Choose a vision care Provider
To receive in-network benefits, participants should receive care from a licensed optometrist, ophthalmologist, or optician that participates in the Blue View Vision Network. Participants should refer to their participating Provider listing to choose a vision care Provider with a location that is convenient for them.

Many participating Providers offer complete vision care services while others may offer only partial services such as dispensing eyeglasses or contact lenses. The key in the Provider listing shows which services each Provider offers.

How to find a vision care Provider in the network
There are three ways a participant can find out if a vision care Provider participates in the Blue View Vision Network:

- Refer to the vision care plan's directory of network Providers at www.anthem.com, which lists vision care Providers that participate in the Blue View Vision Network.
- Call Member Services.
- Check with the vision care Provider.

Out-of-network care
Out-of-Network care refers to vision care services received from a Provider who does not participate in the Blue View Vision Network. Out-of-Network care is covered at a lower level of benefits than in-network care. When a participant seeks care from a licensed optometrist, ophthalmologist, or optician, he will receive a set dollar allowance for Covered Services as stated in the Schedule of Benefits (see Section 7).

What is covered
The vision care plan includes benefits for one routine eye examination per Covered Person each calendar year. In order to receive the highest level of benefits, participants should seek care from a Blue View Vision participating Provider.

What is not covered (Exclusions)
This list of services and supplies that are excluded from coverage by the vision care plan will not be covered in any case. Coverage does not include benefits for the following vision services:

- vision services or supplies unless needed due to eye surgery and accidental injury;
- routine vision care;
- Experimental/Investigative vision procedures or materials, as well as services related to or complications from such procedures;

- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- sunglasses or safety glasses and accompanying frames of any type;
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power;
- any lost or broken lenses or frames;
- any blended lenses (no line), oversize lenses, polycarbonate lenses (for Dependents over the age of 19 and adults), progressive multifocal lenses, photochromatic lenses, Transitions lenses (for Dependents over the age of 19 and adults), tinted lenses, coated lenses, anti-reflective coating, cosmetic lenses or processes, or UV-protected lenses;
- any frame in which the manufacturer has imposed a no discount policy;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the Employer or any government entity; or
- any other vision services not specifically listed as covered.

The coverage also does not include benefits for services or supplies if they are: not listed as covered under the health plan; received before the Effective Date or after a Covered Person's coverage ends; given by a member of the Covered Person's immediate family; provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not a participant waives his rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. The health plan will pay for Covered Services provided under a U. S. government program or a program for which the federal or state government pays all or part of the cost when those program benefits have been exhausted. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government; received from an employer mutual association, trust, or a labor union's medical department; or for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

Claims and payments
The charge is considered to be incurred on the date a service is provided. This is important because participants must be actively enrolled on the date the service is provided. Also, the dates of service will affect a participant's payment allowances and other minimums described in the Schedule of Benefits and in this section.

Blue View Vision participating Providers
If participants go to a Provider that participates with Blue View Vision, the Claims Administrator will pay the Provider directly.

Non-participating Providers
If participants go to a non-participating Provider, the Claims Administrator may choose to pay the participant. It will pay only after it has received an itemized bill and all the information needed to process the claim.

In the event that payment is made directly to a participant, the participant has the responsibility to apply this payment to the claim from the non-participating Provider. In all cases, the payment relieves the health plan of any further liability for the service.

When participants must file a claim
Network Providers file claims on a participant's behalf. Participants may have to file a claim if they receive care from a Provider that does not participate in the Blue View Vision Network. To file a claim, follow these 3 steps:
1. Call 804-358-7390 in Richmond or 800-421-1880 to order a claim form or visit the web site at www.anthem.com for a copy of the claim form.
2. Please include the completed and signed claim form and any itemized bills. Each itemized bill must contain the following:

- name and address of the person or organization providing services or supplies;
- name of the patient receiving services or supplies;
- date services or supplies were provided;
- the charge for each type of service or supply; and
- a description of the services or supplies received.

3. Send the completed claim form and any itemized bills for Covered Services to: Blue View Vision, OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Timely filing of claims
Written notice of a claim is to be made within 20 days after the occurrence or commencement of any service covered by the vision care plan. However, failure to give this notice shall not invalidate or reduce any claim if the notice is given as soon as reasonably possible. Claim forms will be furnished to participants if needed within 15 days after this written notice.

The written claim must be furnished within 90 days after the date of service. A claim is not complete unless it is properly filed and contains all information that the Claims Administrator needs to process the claim. Failure to furnish the claim within this time frame will not invalidate or reduce any claim if the claim is given as soon as reasonably possible. However, no claim will be paid if it is received more than 12 months after the date of service, except in the absence of legal capacity of the Covered Person. All benefits payable for a claim will be payable within 60 days after receipt of the claim.

When a participant's claim is processed
In processing a participant's claim, the participant's vision care plan may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the **"When participants must file a claim"** paragraph of this section will be processed within 30 days of receipt of the claim. The Claims Administrator may extend this period for another 15 days if it is determined it to be necessary because of matters beyond its control. In the event that this extension is necessary, participants will be notified prior to the expiration of the initial 30-day period.

The vision care plan may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by a participant or his Provider furnishing the additional information. The participant or his Provider must submit the additional information to us within either 15 months of the date of service or 45 days from the date the participant was notified that the information was needed, whichever is later. Once the claim has been processed by the participant's vision care plan, he will receive written notification of the coverage decision. In the event of an Adverse Benefit Determination, the written notification will include the following:

- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed; and a description of the vision care plan's appeal procedures and applicable time limits. If all or part of a claim was not covered, the participant has a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the vision care plan relied upon in making the coverage decision.

Recovery of overpayment
The health plan shall have the right to recover any overpayment of benefits from persons or organizations that are determined to have realized benefits from the overpayment:

- any person to, or for whom such payments were made;
- any insurance company;
- a facility or Provider; or
- any other organization.

Participants will be required to cooperate with us to secure the health plan's right to recover the excess

payments made on their behalf, or on behalf of Covered Persons enrolled under their family coverage.

Definitions for the Blue View Vision Program

Adverse Benefit Determination is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the health plan.

Blue View Vision Network is a network of eye care Providers, including optometrists, ophthalmologists, and opticians. To receive the highest level of benefits, a participant should seek care from a Provider that participates in the Blue View Vision Network.

Claims Administrator is the third party administrator appointed by the Plan to process and administer the claims under the Plan. The Claims Administrator for the Plan is listed in Appendix A.

Coinsurance is the percentage of the allowable charge a participant pays for some Covered Services.

Copayment is the fixed dollar amount participants pay for some Covered Services.

Covered Persons are the participant and enrolled eligible Dependents.

Effective Date is the date coverage begins for the participant and/or his Dependents enrolled under the vision care plan.

Group Administrator is the benefits administrator at Henrico County General Government and Henrico County Public Schools.

In-network is care rendered by a Blue View Vision participating Provider. In-network benefits are the highest level of benefits available under the vision care plan.

Out-of-Network is care that is not rendered by a Blue View Vision participating Provider. Out-of-Network care is covered at a lower level of benefits.

Participant is any member.

Post-service Claims are all claims other than Pre-service Claims. Post-service Claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where a participant requests authorization in advance.

Pre-service Claims are claims for a service where the terms of the health plan require the participant to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If a participant calls to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim. **Providers** are licensed eye care professionals, including ophthalmologists, optometrists, and opticians.

The vision care plan is the Blue View Vision care plan offered with the health plan.

SECTION 11
PLAN EXCLUSIONS

This list of services and supplies that are excluded from coverage by the health plan will not be covered in any case.

A

The health plan does not include benefits for **acupuncture**

Services not **authorized in advance** by the Claims Administrator and pre-arranged by the member's primary care physician unless otherwise specified.

B

The health plan does not include benefits for **biofeedback therapy**

C

The health plan does not include benefits for:

- over the counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, diapers, and ice bags; or

- benefits for, or related to, **cosmetic surgery or procedures,** including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. The patient's mental state will not be considered in deciding if the surgery is cosmetic.

D

The health plan does not include benefits for the following **dental** services:

- treatment of natural teeth due to accidental injury occurring on or after a participant's Effective Date of coverage, unless treatment was sought within 60 days after the injury and the participant submitted a treatment plan to the Claims Administrator for prior approval;
- treatment of natural teeth due to diseases;
- restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth;
- dental care, treatment, supplies, or dental x-rays;
- shortening or lengthening of the mandible or maxillae for cosmetic purposes;
- surgical correction of malocclusion or mandibular retrognathia unless such condition creates significant functional impairment that cannot be corrected with orthodontic services;
- biting and chewing related injuries unless the chewing or biting results from a medical or mental condition;
- appliances to treat temporomandibular joint pain dysfunction syndrome or correct malocclusion or mandibular retrognathia;
- oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures;
- medications to treat periodontal disease;

- periodontal care, prosthodontal care or orthodontic care;
- anesthesia and hospitalization for dental procedures and services **except** covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are provided when it is determined by a licensed dentist, in consultation with the covered persons' treating physician that such services are required to effectively and safely provide dental care.

The health plan does not include benefits for **donor** searches for organ and tissue transplants, including compatibility testing of potential donors unless they are immediate, blood-related family members (parent, Child, sibling).

E

The health plan does not include benefits for services or supplies primarily for **educational,** vocational, or self management training purposes, except as otherwise specified in this Plan Document or when received as part of a covered wellness services Visit or screening.

The health plan does not include benefits for **Experimental/Investigative** procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. The criteria for deciding whether a service is Experimental/Investigative or a clinical trial cost for cancer is set forth in **Exhibit A.**

F

The health plan does not include benefits for the following **family planning** services:

- services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- any services or supplies provided to a person not covered under the health plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a Child by another woman for an infertile couple);
- drugs used to treat infertility;
- services to reverse voluntarily induced sterility;
- non-prescription contraceptive devices..

The health plan does not include benefits for palliative or cosmetic **foot** care including:

- flat foot conditions;
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
- foot orthotics;
- subluxations of the foot;
- corns (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- calluses (except as treatment for patients with diabetes or vascular disease);
- care of toenails (except as treatment for patients with diabetes or vascular disease);
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

G

The health plan does not include services for surgical treatments of **gynecomastia** for cosmetic purposes.

H

The health plan does not include benefits for **health club memberships,** exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

The health plan does not include benefits for **hearing care** except in relation to preventive care screenings (Implantable or removable hearing aids, except for cochlear implants, are not covered.)

The health plan does not include benefits for the following **Home Care Services**:

- homemaker services (except as rendered as part of Hospice care);
- maintenance therapy;
- food and home delivered meals; or
- custodial care and services.

The health plan does not include benefits for the following **hospital** services:

- guest meals, telephones, televisions, and any other convenience items received as part of an Inpatient stay;
- care by interns, residents, house physicians, or other facility employees that are billed separately from the facility; or
- a private room unless it is Medically Necessary and approved by the Claims Administrator.

I

The health plan does not include benefits for **immunizations** required for travel and work, unless such services are received as part of the covered preventive care services.

M

The health plan does not include benefits for **Medical Equipment (Durable), appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use. These include:

- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens;
- whirlpool baths;
- handrails, ramps, elevators, and stair glides;
- telephones;
- adjustments made to a vehicle;
- foot orthotics;
- changes made to a home or place of business;
- repair or replacement of equipment a participant loses or damages through neglect.

The health plan does not include benefits for **Medical Equipment (Durable)** that is not appropriate for use in the home.

The health plan does not include benefits for services and supplies if they are deemed not **Medically Necessary** as determined by the Claims Administrator at its sole discretion. Notwithstanding this exclusion, all wellness services and hospice care services that are described in this Plan Document are covered. This exclusion shall not apply to services participants receive on any day of Inpatient care that is determined by the Claims Administrator to be not Medically Necessary if such services are received from a professional provider who does not control whether the participant is treated on an Inpatient basis or as an Outpatient, such as a pathologist, radiologist, anesthesiologist or consulting physician. Additionally, this exclusion shall not apply to Inpatient services rendered by the admitting or attending physician other than Inpatient evaluation and management services provided to the participant notwithstanding this

exclusion. Inpatient evaluation and management services include routine Visits by the admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and management Visits do not include surgical, diagnostic, or therapeutic services provided by the admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or anesthesiologists in an (i) Outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist, or anesthesiologist assumes the role of attending physician. This will not prevent a member from being able to appeal the Claims Administrator's decision that a service in not Medically Necessary. Nothing in this exclusion shall prevent a participant from appealing the Claims Administrator's decision that a service is not Medically Necessary.

The health plan does not include benefits for the following **Mental Health Services and substance abuse services:**

- Inpatient stays for environmental changes;
- cognitive rehabilitation therapy;
- educational therapy;
- vocational and recreational activities;
- coma stimulation therapy;
- services for sexual deviation and dysfunction;
- treatment of social maladjustment without signs of a psychiatric disorder;
- remedial or special education services;
- Inpatient mental health treatments that meet the following criteria:
    - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the Inpatient treatment program of the hospital;
    - group psychotherapy when there are more than 8 patients with a single therapist;
    - group psychotherapy when there are more than 12 patients with two therapists;
    - more than 12 convulsive therapy treatments during a single admission;
    - psychotherapy provided on the same day of convulsive therapy.

N

The health plan does not include benefits for **nutritional and/or dietary supplements,** except as specifically provided under the health plan, when provided as part of diabetes education, for treatment of an eating disorder, or when received as part of a covered wellness services Visit,. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

O

The health plan does not include benefits for **obesity** services and supplies related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not Covered Services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

The health plan does not include benefits for **organ** or tissue transplants, including complications caused by them, except when they are considered Medically Necessary, have received preauthorization, and are not considered Experimental/Investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with the protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the health plan of experimental/investigative services.

P

The health plan does not include benefits for **paternity testing.**

The **prescription drug** benefit does not include coverage for:

- over-the-counter drugs except as specified in this Plan Document;
- any per unit, per month quantity over the plan's limit;
- drugs used mainly for cosmetic purposes;
- drugs that are experimental, investigational, or not approved by the FDA;
- cost of medicine that exceeds the Maximum Allowed Amount for that prescription;
- drugs for weight loss;
- stop smoking aids except as specifically outlined in this Plan Document;
- therapeutic devices or appliances;
- injectable Prescription Drugs that are supplied by a Provider other than a pharmacy;
- charges to inject or administer drugs;
- drugs not dispensed by a licensed pharmacy;
- drugs not prescribed by a licensed Provider;
- infertility medication;
- any refill dispensed after one year from the date of the original prescription order;
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies; or
- medicine furnished by any other drug or medical service.

The health plan does not include benefits for **private duty nurses** in the Inpatient Setting.

R

The health plan does not include benefits for **rest cures**, custodial, **residential,** or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether a participant receives active 24-hour skilled professional nursing care, daily physician Visits, daily assessments, and structured therapeutic services.

S

The health plan does not include benefits for **services or supplies** or devices if they are:

- received from providers not licensed by law to provide covered services defined in this Plan Document. Examples include masseurs (massage therapists), physical therapist technicians and athletic trainers);
- care of any type given along with the services of an attending Provider whose services are not covered;
- benefits for charges from stand-by physicians in the absence of Covered Services being rendered;
- not listed as covered under the health plan;
- not prescribed, performed, or directed by a Provider licensed to do so;
- received before the Effective Date or after a Covered Person's coverage ends;
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms;
- for travel, whether or not recommended by a physician;
- services prescribed, ordered, referred by, or received from a member of a participant's immediate family, including his Spouse, Child, brother, sister, parent, in-law or self;
- under the Medicare program or under any similar program authorized by state or local laws or regulations, or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payor after benefits under this plan have been paid;
- provided under a U.S. government program or a program for which the federal or state government

pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;
- for injuries or illnesses incurred as a result of a participant's commission of, or attempt to commit, a crime; or
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

The health plan does not include benefits for **services** for which a charge is not usually made. This includes services for which a participant would not have been charged if he did not have health care coverage. The health plan does not include benefits for:
- amounts above the Maximum Allowed Amount for a service;
- penile implants;
- self-administered services or self-care including self-administered injections;
- self-help training;
- biofeedback, neurofeedback, and related diagnostic tests.

The health plan does not include benefits for **services or supplies** primarily for educational, vocational, or self-management/training purposes, except as otherwise specified, except when received as part of a covered wellness services Visit or screening.

The health plan does not include benefits for surgeries for **sexual dysfunction.** In addition, the health plan does not include benefits for services for **sex transformation.** This includes medical and Mental Health Services.

The health plan does not include benefits for the following **Skilled Nursing Facility** stays:
- treatment of psychiatric conditions and senile deterioration;
- facility services during a temporary leave of absence from the facility; or
- a private room, unless it is Medically Necessary.

The health plan does not include benefits for **smoking cessation** programs not affiliated with the plan.

The POS and Lumenos HSA plans do not include benefits for **spinal manipulations** or other manual medical Interventions for the following:
- any treatment or service not authorized by American Specialty Health Group (ASHG);
- services for examination and/or treatment of strictly non-neuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment;
- laboratory tests x-rays, adjustments, physical therapy or other services not documented as medically necessary and appropriate or classified as experimental/investigative or in the research stage;
- diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans and/or other types of diagnostic scanning, thermography;
- educational programs, non-medical self-care and or self-help, or any self-help physical exercise training or any related diagnostic training;
- air conditioners, air purifiers, therapeutic mattresses, supplied or any similar devices or appliances;
- vitamins, mineral, nutritional supplements or any other similar type product

The PPO plan does not include benefits for **spinal manipulations** or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

T

The health plan does not include benefits for non-interactive **Telemedicine Services.** Non-interactive Telemedicine Services, include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

The health plan does not include benefits for the following **therapies**:

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services;
- group speech therapy;
- group or individual exercise classes or personal training sessions; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

V

The health plan does not include services for treatment of varicose **veins** or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

The health plan does not include benefits for the following **vision** services (except as provided through Blue View Vision):

- vision services or supplies unless needed due to eye surgery and accidental injury;
- routine vision care and materials;
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and /or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- tests associated with the fitting of contact lenses or Plano lenses or lenses that have no refractive power unless the contact lenses are needed due to eye surgery or to treat accidental injury;
- sunglasses or safety glasses and accompanying frames of any type;
- any non-prescription lenses, eyeglasses or contacts or Plano lenses or lenses that have no refractive power
- any lost or broken lenses or frames;
- any blended lenses (no line), oversize lenses, progressive multi focal lenses, photo chromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the Employer or any government entity;
- any other vision services not specifically listed as covered.

W

The health plan does not include benefits for **weight loss programs** whether or not they are pursued under medical or physician supervision, unless specifically listed as covered under the health plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss, etc.) and fasting programs.

The health plan does not include benefits for services or supplies if they are for **work-related** injuries or diseases when the Employer must provide benefits by federal, state, or local law or when that person has been paid by the Employer. This exclusion applies even if the participant waives his right to payment under these laws and regulations or fails to comply with his Employer's procedures to receive the benefits. It also applies whether or not the Covered Person reaches a settlement with his or her Employer or the Employer's insurer or self insurance association because of the injury or disease.

SECTION 12
CLAIMS AND PAYMENTS

The health plan considers a charge to be incurred on the date a service is provided. This is important because participants must be actively enrolled on the date the service is provided. Also, the dates of service will affect a participant's Deductible and other minimums described in the Schedule of Benefits (in Section 7) and in this section.

Calendar Year Deductible
The Anthem HealthKeepers Standard POS and Premier POS plans and the KeyCare PPO plan include an In-network calendar year Deductible and an Out-of-Network calendar year Deductible for Covered Services. Before the plan will make payments for Covered Services received In-network or Out-of-Network (if applicable), a participant must first satisfy the Deductible. The In-network Deductible is separate from the Out-of-Network Deductible, and they do not accumulate with each other. See the Schedule of Benefits in Section 7 of this Plan Document for the calendar year Deductible amounts.

The Lumenos HSA plan includes a combined calendar year Deductible to which Covered Services received both In-network and Out-of-Network (if applicable) accumulate. See the Schedule of Benefits in Section 7 of this Plan Document for the calendar year Deductible amounts.

Limits on a participant's out-of-pocket expenses
The health plan protects participants from large out-of-pocket expenses by limiting the amount they spend out of their own pocket each year. Once the limit on a participant's health plan is reached, almost all other covered expenses are paid in full for the rest of the calendar year.

What a participant will pay
Deductibles, Copayments and Coinsurance (if any) for certain Covered Services are outlined in the Schedule of Benefits. These amounts are the participant's financial responsibility. Copayments should be paid by or on behalf of the participant at the time the Covered Service is rendered. Applicable Deductible and/or Coinsurance may also be collected.

The health plan benefits may contain one Copayment which covers all prenatal and postnatal Visits for each pregnancy. In most cases, this will be a more favorable benefit than paying the specialist Copayment for each prenatal and postnatal Visit. If, for any reason, a participant's per-pregnancy Copayment exceeds the total Copayments they would have paid if they had paid their specialist Copayment for each prenatal and postnatal Visit, the Claims Administrator or the Provider will reimburse the participant the difference between the per-pregnancy Copayment and the total per Visit specialist Copayments they would have paid for all prenatal and postnatal Visits during any one pregnancy.

In-network limit
Deductibles, Copayments, and Coinsurance for services by Providers and facilities within the HealthKeepers and KeyCare networks count toward the participant's in-network, out-of-pocket expense limit. When a participant's in-network, out-of-pocket expense limit is reached, Deductibles and Coinsurance for in-network services will no longer apply for the rest of the calendar year. Two special situations when expenses will also count toward this limit are:

- when a participant receives services from medical suppliers for whom there is no network, the participant's out-of-pocket expenses count toward this limit; and
- when specialty care is not available within the network and the Claims Administrator authorizes the highest level of benefits, any Deductibles and Coinsurance for these Covered Services count toward this limit.

Out-of-Network limit
Deductibles and Coinsurance for Covered Services by Providers and facilities who are not part of the HealthKeepers Network or the KeyCare network, but who participate in an Anthem or Blue Cross and Blue Shield Company's network, count toward a participant's Out-of-Network, out-of-pocket expense

limit. If a participant reaches his Out-of-Network, out-of-pocket expense limit, he will no longer pay Coinsurance for Out-of-Network services for the rest of the calendar year

What does not count toward these limits
The following amounts do not count toward a participant's out-of-pocket expense limit, and the participant will always be responsible for these expenses, regardless of whether it has met its out-of-pocket expense limit.

- amounts above the Maximum Allowed Amount;
- amounts above health plan limits;
- expenses for supplies or services not covered by the health plan;
- routine vision exams.

How the Claims Administrator pays a claim
How the Claims Administrator pays a claim takes into account the Maximum Allowed Amount for the service, the network status of the Provider or facility where a participant receives services, and his cost share under the health plan's benefit design. Each of the components is explained below.

Maximum Allowed Amount
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 the Plan's Maximum Allowed Amount for the Covered Service that a participant received. Please see the BlueCard section for additional information.

The Maximum Allowed Amount for the health plan is the maximum amount of reimbursement the Claims Administrator will allow for services and supplies:

- that meet the health plan's definition of Covered Services, to the extent such services and supplies are covered under the health 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.

Participants will be required to pay a portion of the Maximum Allowed Amount to the extent they have not met their Deductible or have a Copayment or Coinsurance. In addition, when they receive Covered Services from non-participating Providers, they may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges This practice is commonly referred to as "balance billing". **This amount can be significant.**

When participants receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowed Amount. The application of these rules does not mean that the Covered Services a participant received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, a participant's 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.

Maximum Allowed Amount for multiple procedures
When multiple procedures are performed on the same day by the same physician or other healthcare professional, the Claims Administrator 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.

Assistant at surgery
Services of a physician who actively assists the operating surgeon to perform a covered surgical service are Covered Services. However, when two or more surgeons provide a covered surgical service that could have been performed by one surgeon, the Maximum Allowed Amount will not be more than that available to one surgeon.

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

If a participant is enrolled in the POS or Lumenos HSA plan, the Maximum Allowed Amount may vary depending upon whether the Provider is a network Provider or a non- network Provider. A network Provider is a Provider who is in the HealthKeepers network. For Covered Services performed by a network Provider, the Maximum Allowed Amount for this plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because network Providers have agreed to accept the Maximum Allowed Amount as payment in full for that service, they should not send participants a bill or collect for amounts above the Maximum Allowed Amount. However, a participant may receive a bill or be asked to pay a portion of the Maximum Allowed Amount if he has not met his Deductible, Copayment or Coinsurance if any.

If a participant is enrolled in the PPO plan, an in-network Provider is a Provider who is in the KeyCare PPO Network, the managed network for this specific health plan. For Covered Services performed by an in-network Provider, the Maximum Allowed Amount for a participant's health plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services.

Providers who are not in the KeyCare PPO Network, but are contracted for other products are considered non-network participating Providers. While a participant's cost share may be higher because these Providers are not in-network, these non-network participating Providers have agreed to accept the Maximum Allowed Amount established by the Provider's contract as payment in full for those Covered Services. Choosing an in-network Provider will likely result in lower out-of-pocket costs to the participant.

Because in-network Providers and non-network participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send participants a bill or collect for amounts above the Maximum Allowed Amount. However, a participant may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent he has not met his Deductible or has a Copayment or Coinsurance. Please call Member Services for help in finding an 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 networks are Out-of-Network Providers. For Covered Services participants receive from an Out-of-Network Provider, the Maximum Allowed Amount for the health plan will be one of the following as determined by the Claims Administrator:

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

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

Certain Covered Services such as medical supplies, ambulance, early intervention services, Home Care Services, private duty nursing, medical equipment, and medical formulas, may be rendered by persons or entities that are not Providers. There may or may not be networks established for these persons or entities. The Maximum Allowed Amount for services from these persons or entities will be determined in the same manner as described above for Providers. For Prescription Drugs and diabetic supplies rendered by a pharmacy, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the pharmacy benefits manager.

Member cost share
For certain Covered Services, and depending on a participant's benefits, he may be required to pay a part of the Maximum Allowed Amount as his cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

A participant's cost share amount and out-of-pocket limits may vary depending on the plan in which he is enrolled and whether he received services from an in-network or Out-of-Network Provider. Specifically, he may be required to pay higher cost sharing amounts or may have limits on his benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in Section 7 for the cost share responsibilities and limitations, or call the Claims Administrator's Member Services to learn how this plan's benefits or cost share amounts may vary by the type of Provider a participant uses.

The Claims Administrator will not provide any reimbursement for non-Covered Services. A participant may be responsible for the total amount billed by his Provider for non-Covered Services, regardless of whether such services are performed by an in-network or Out-of-Network Provider. Both services specifically excluded by the terms of the policy/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, a participant may only be asked to pay the lower in-network cost sharing amount when he uses an Out-of-Network Provider. For example, if he goes to an in-network hospital or Provider facility and receives 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, he will pay the in-network cost share amounts for those Covered Services. However, he also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

In some instances, because of the negotiated arrangement with network facilities and Providers, the Maximum Allowed Amount may be higher than the facility or Provider billed charge for the Covered Services. In these cases, any Coinsurance amount that the health plan imposes will be based off the lower billed charges.

Example: The health plan has a Coinsurance cost share of 20% for in-network services, and 30% Out-of-Network after the in- or Out-of-Network Deductible has been met. A participant undergoes a surgical procedure in an in-network hospital. The hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. The participant has no control over the anesthesiologist used.

- the Out-of-Network anesthesiologist's charge for the service is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; the participant's Coinsurance responsibility is 20% of $950, or $190 and the remaining allowance from the health plan is 80% of $950, or $760.

The participant may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, his total out-of-pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.

- a participant chooses an in-network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; the participant's Coinsurance responsibility when an in-network surgeon is used is 20% of $1500, or $300. The health plan allows 80% of $1500, or $1200. The in-network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. The participant's total out-of-pocket responsibility would be $300.
- a participant chooses an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; the participant's Coinsurance responsibility for the Out-of-Network surgeon is 30% of $1500, or $450 after the Out-of-Network Deductible has been met. The health plan allows the remaining 70% of $1500, or $1050. In addition, the Out-of-Network surgeon could bill the participant the difference between $2500 and $1500, so his total out-of-pocket charge would be $450 plus an additional $1000, for a total of $1450.

Authorized services

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

Example: A participant requires the services of a specialty Provider, but there are no in-network Providers for that specialty in the participant's state of residence. The participant contacts the Claims Administrator in advance of receiving any Covered Services, and is authorized to go to an available Out-of-Network Provider for that Covered Service and the Claims Administrator agrees that the in-network cost share will apply.

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

Because the plan has authorized the in-network cost share amount to apply in this situation, the participant will be responsible for the in-network Copayment of $25 and the Claims Administrator will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

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

Network and participating Providers and facilities

If a participant goes to a network or participating Provider or facility, the health plan will pay the Provider or facility directly. If Coinsurance or a Copayment is applicable to Covered Services rendered by a network or participating facility or Provider, or if any applicable Deductible is not met, any such amounts may be collected at the time of service.

Non-participating Providers and facilities
If a participant goes to a non-participating Provider or facility, the Plan may choose to pay him or anyone else responsible for paying the bill. The Claims Administrator will pay only after receiving an itemized bill or proof of service and all the medical information needed to process the claim. The health plan will not pay a non-participating Provider more than a participating Provider would have been paid for the same service.

In the event that payment is made directly to the participant, he has the responsibility to apply this payment to the claim from the non-participating Provider.

When a participant must file a claim
Network Providers file claims on a participant's behalf. The participant may have to file a claim if he receives care from a Provider or facility that does not participate in the Claims Administrator's network. The participant will have to file a claim if he receives care billed by someone other than a doctor or hospital, or if the Provider cannot file a claim for him. To file a claim follow these 3 steps:

1. Call 804-358-1551 in Richmond or 800-451-1527 to order a claim form or get one from the Group Administrator.

2. Please include the completed and signed claim form and any itemized bills for Covered Services. Each itemized bill must contain the following:
   - name and address of the person or organization providing services or supplies;
   - name of the patient receiving services or supplies;
   - date services or supplies were provided;
   - the charge for each type of service or supply;
   - a description of the services or supplies received; and
   - a description of the patient's condition (diagnosis).

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

3. Send the completed claim form and any itemized bills for Covered Services to:
   Anthem Blue Cross and Blue Shield
   P. O. Box 27401
   Richmond, VA 23279

Timely filing of claims
A written claim must be furnished within 90 days after the date of service. A claim is not complete unless it is properly filed and contains all information that the Claims Administrator needs to process the claim. Failure to furnish the claim within this time frame will not invalidate or reduce any claim if it is provided as soon as reasonably possible. However, no claim will be paid if is received more than 15 months after the date of service, except in the absence of legal capacity of the Covered Person.

When a participant's claim is processed
In processing a participant's claim, the health plan may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the **"When a participant must file a claim"** paragraph of this section will be processed within 30 days of receipt of the claim. The Claims Administrator may extend this period for another 15 days if it determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, the participant will be notified prior to the expiration of the initial 30-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, the Claims Administrator will make a decision within 2 working days of its receipt of the medical information needed to process the claim.

The health plan may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by a participant or his Provider furnishing the additional information. A participant or his Provider must submit the additional information to the Claims Administrator within either 15 months of the date of service or 45 days from the date the participant was notified that the information was needed,

whichever is later. Once a participant's claim has been processed by the health plan, the participant will receive written notification of the coverage decision. In the event of an Adverse Benefit Determination, the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of the health plan's appeal procedures and applicable time limits; and
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist participants with the internal or external appeals process.

If all or part of a claim was not covered, participants have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the health plan relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, participants are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to their medical condition.

Recovery of overpayments

The Claims Administrator shall have the right to recover any overpayment of benefits from persons or organizations that are determined to have realized benefits from the overpayment:

- any person to, or for whom, such payments were made;
- any insurance company;
- a facility or Provider; or
- any other organization.

A participant will be required to cooperate with the Claims Administrator to secure their right to recover the excess payments made on the participant's behalf, or on behalf of Covered Persons enrolled under the participant's family coverage. Under certain circumstances, if the health plan pays the health care Provider amounts that are the participant's responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from him. Participants agree that the Claims Administrator has the right to collect such amounts from them.

SECTION 13
COORDINATION OF BENEFITS

All benefits provided under this health plan are subject to special coordination of benefits (COB) rules that apply when participants or members of their family have additional health care coverage through other group health plans. Benefits will not be increased by this COB provision, and this provision applies if the total payment under this plan, absent this provision and under any other contract, is greater than the value of Covered Services. Other coverage means any arrangement providing health care benefits or services, including:

- group or blanket insurance plans, including other group Blue Cross and Blue Shield plans, health maintenance organization (HMO), point of service (POS) plans, and other prepayment coverage;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

If there is more than one form of other coverage, this provision will apply separately to each. If the other coverage has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph will be applied separately to that part and to any other part.

When benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the benefit.

The Claims Administrator will not determine the existence of any other coverage, or the amount of benefits payable under any other coverage except this health plan. The payment of benefits under this health plan shall be affected by the benefits payable under other coverage only when the Claims Administrator is given information about the other coverage.

If the rules of this health plan and the other coverage both provide that this health plan is primary, then this health plan is primary. When the Claims Administrator determines that this health plan is secondary under the rules described below, benefits will be reduced so that our payment plus the other contract's payment will not exceed the Claims Administrator's Maximum Allowed Amount for Covered Services.

Primary coverage and secondary coverage
When a Covered Person is also enrolled in another group health plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using thefollowing order of benefit determination rules:

- If coverage under a contract is taken out in the name of a Covered Person, then that contract will be primary for that Covered Person. However, if the person is also entitled to Medicare, and as a result of federal law Medicare is:
    - secondary to the contract covering the person as a Dependent; and
    - primary to the contract covering the person as other than a Dependent (e.g. a retired Employee);
- then the benefits of the contract covering the person as a Dependent are determined before those of the contract covering the person as other than a Dependent.
- For children who are covered under both parents' contracts, the following will apply:
    - The contract of the parent whose birthday occurs earlier in the calendar year will be primary.
    - When parents are separated or divorced, the following special rules will apply:
        - If the parent with custody has not remarried, that parent's contract will be primary.
        - If the parent with custody has remarried, that parent's contract will be primary and the stepparent's contract will be secondary. The benefits of the contract of the parent without custody will be determined last.
- The rules listed above may be changed by a court decree:

    - A court decree that orders one of the parents to be responsible for health care expenses will cause that parent's contract to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
    - If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the contract of the parent whose birthday occurs earlier in the calendar year will be primary.
    - If the other contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's contract will be primary for the children.
    - If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working Employee (or his Dependent) will be primary. The policy or plan of a laid-off Employee, a retired Employee, or a person on continuation of coverage options under federal or state law will be secondary.
- If another policy or plan has different rules from those listed above other than the gender rule, that policy or plan will be primary.

When this health plan provides secondary coverage, the amount that would have been payable had this health plan been primary will be calculated first. In no event will this health plan's payment as secondary coverage exceed that amount. This health plan coordinates benefits so that the combination of the primary plan's payment and this health plan's payment does not exceed the Maximum Allowed Amount. When the primary coverage provides benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the benefit payment.

SECTION 14
PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

14.1 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or Mental Health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care Providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employer.

(a) **Updates Required.** The Plan Sponsor shall amend the Plan promptly with respect to any changes in the members of the Employer's workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of the Employer's workforce are designated as authorized to receive Protected Health Information from the Plan in order to perform their duties with respect to the Plan.

- Benefits Manager, Henrico County General Government and Health Benefits Staff
- Accounting Section Manager, Henrico County Public Schools and Health Benefits Staff
- Director of Human Resources, Henrico County
- Assistant Director of Human Resources, Henrico County
- Members of the Henrico County Employee Health Benefits Committee
- Payroll Staff, Henrico County and Public Schools
- Privacy Official, Henrico County
- Budget Analyst/Health Care Administration/Finance, Henrico County

14.2 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employer described above.

SECTION 15
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the County of Henrico, Virginia Health Plan (the Plan) will be entitled to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Participants, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is County of Henrico, Virginia. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any Child who is born to or Placed for Adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term “covered Employee” includes eligible Employees (whether part-time or full-time) as well as any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

Each Qualified Beneficiary (including a Child who is born to or Placed for Adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent Child ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), the Qualified Beneficiary or someone on his behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. This notice must be sent to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice must be **in writing**. Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand-delivered to the department listed below, at the following address:

General Government and Economic Development Authority:
Henrico County Human Resources Department
Benefits Division
P.O. Box 90775
Henrico, VA 23273
Fax: (804) 501-4426

Henrico County Public Schools:
Health Benefits Office
P.O. Box 23120
Henrico, VA 23223
Attention: Health Benefits
Fax: (804) 652-3988

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice that is provided must state:

- the **name of the plan or plans** under which coverage has been lost or is being lost;
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce**, the notice must include **a copy of the divorce decree.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If the Employee or his Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

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

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an

interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

(5) The day the Qualified Beneficiary is first enrolled in the Medicare program (either Part A or Part B). The Qualified Beneficiary must immediately notify the Plan Administrator of any such enrollment in Medicare. The notice must be provided as described in the Notice Procedures above.

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) **(i)** 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a Child born to or Placed for Adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or Placed for Adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the Claims Administrator, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SECTION 16
QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES

16.1 IN GENERAL

In the case of any medical Child support order ("Order") that is received with respect to the Plan, its status shall be determined in accordance with the provisions set forth in this Section.

16.2 NOTIFICATION OF RECEIPT

Promptly upon receipt of an Order, the Plan Administrator will notify in writing each person named therein, at the address specified in the Order (if applicable), of the receipt by the Plan of the Order and forward to them notification of the procedures set forth in this Section. If the Plan Administrator is able to determine whether an Order is qualified promptly upon receipt of such Order, the Plan Administrator may send one notice which informs each person named herein both of the receipt of the Order and of the Plan Administrator's determination, as provided in Section 16.5 and 16.6.

16.3 REVIEW OF ORDER

The Plan Administrator will ascertain, with the assistance of legal counsel, as appropriate, whether:

(1) The Order is a judgement, decree, or order (including approval of a property settlement agreement) issued either by a court of competent jurisdiction, or through an administrative process established under state law that has the force and effect of law under applicable state law, which:

(a) provides for Child support with respect to a Child of a Participant under a group health plan or provides for health benefit coverage to such a Child under this Plan, made pursuant to a state domestic relations law (including a community property law), or

(b) enforces a state medical Child support law enacted under the Social Security Act with respect to a group health plan;

(2) The Order specifies the name and the last known full mailing address (if any) of the Participant and each alternate recipient covered by the Order, or if not, that the information is available from the records of the Plan or Employer;

(3) The Order clearly identifies the Plan or plan(s) to which it applies;

(4) The Order clearly specifies a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;

(5) The Order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirement of a law relating to medical Child support under the Social Security Act; and

(6) The Order clearly specifies the period to which it applies including the Effective Date of coverage.

Provided, however, any appropriately completed National Child Support Notice, issued pursuant to the Child Support Performance and Incentive Act of 1998, shall be deemed to satisfy the requirements to be a "qualified medical support order."

16.4 SUSPENSION OF CLAIMS

Claims for a proposed alternate recipient shall be suspended until the Plan Administrator has determined whether the order in question is qualified.

16.5 NOTIFICATION OF STATUS

When the Plan Administrator determines whether the Order satisfies the requirements to be a Qualified Medical Child Support Order, the Plan Administrator shall notify in writing all persons named in the Order and any representatives designated in writing by such persons ("Interested Parties") of the determination as soon as practicable following such determination

(1) If no Interested Party disputes this determination within thirty (30) days of receipt of such notice, or if all Interested Parties agree in writing not to dispute the Plan Administrator's determination, the Plan Administrator shall proceed with implementing the Order as a Qualified Medical Child Support Order.

(2) If any Interested Party disputes this determination within thirty (30) days of receipt of such notice, then the suspension of claims provided in Section 16.4 shall continue and the Interested Party disputing the determination may request a review of the determination in accordance with the claims procedures set forth in the Plan.

16.6 NOTIFICATION OF NON-QUALIFIED STATUS

If the Plan Administrator determines that the Order is not a Qualified Medical Child Support Order, the Plan Administrator shall notify in writing all Interested Parties of its determination, and such notice will state the reasons for such determination. Following such determination, any Interested Parties may re-submit a revised Order to the Plan Administrator.

SECTION 17
NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans 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, after consulting with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a Provider obtain authorization from the plan for prescribing a length of Stay not in excess of 48 hours (or 96 hours).

SECTION 18
WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If a female Participant has had or is going to have a mastectomy, she may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related services, 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 the Plan.

SECTION 19
MISCELLANEOUS

19.1 AMENDMENT AND TERMINATION OF PLAN

The County fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason provided no such action shall adversely affect any claims that have actually been incurred by a Participant that would otherwise be eligible for payment under the Plan as in effect when the expense was incurred.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Participants are limited to Covered Charges incurred before termination, amendment or elimination.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

19.2 PRIVACY OF HEALTH INFORMATION

The provisions set forth in Section 14 concerning the use of protected health information by any Employees of the Employer named in Section 3 of this document, acting in the capacity as Plan Sponsor, and/or agents or subcontractors, shall apply with respect to any group health care benefits subject to the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and its implementing regulations.

19.3 INFORMATION TO BE FURNISHED

Participants shall provide the Employer and Plan Administrator with such information and evidence, and shall sign such documents as may reasonably be requested from time to time for the purpose of administration of the Plan.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all.

19.4 PLAN'S RIGHT TO REDUCE OR DENY BENEFITS

Reimbursement from the Plan may be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

19.5 NO GUARANTY OF TAX TREATMENT

The Plan Administrator does not make any representation, commitment, or guaranty that the value of any coverage and any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or statement income tax purposes, or that any specific federal or state tax treatment will apply or be available to any Participant.

19.6 INCAPACITY

If a Participant is, in the judgment of the Plan Administrator, legally, physically, or mentally incapable of personally receiving any payment due under the Plan, the Plan Administrator may direct payments due to such other person or institution who, in the opinion of the Plan Administrator, are then maintaining or having custody of such Participant until claim is made by a duly appointed guardian or other legal representative of such Participant. Such payment shall constitute a full discharge of liability of the Plan to the extent of such payment.

19.7 ALIENATION OF INTERESTS

Benefits under this Plan may not be assigned or alienated.

19.8 UNCLAIMED PAYMENTS

Checks that are issued by the Plan for benefit payments and that are not cashed within 90 days may be voided. A new check will be issued upon request of the party entitled to payment.

19.9 RECOVERY OF BENEFITS

If a Participant receives a benefit payment under the Plan in excess of the benefit payment that should have been made, the Plan or its agent shall have the right to recover such excess from the Participant. The Plan may, however, at its option, deduct the amount of such excess for any subsequent benefits payable to or for such Participant.

19.10 SCOPE OF LEGAL RIGHTS

Except as provided herein, neither the establishment nor maintenance of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving any Participant or other person any legal or equitable right against the Employer or Plan Administrator. Furthermore, the adoption and maintenance of the Plan shall not be deemed to constitute or modify a contract, if any, between the Employer and any Employee or Participant or to be consideration, inducement for, or condition of the performance of services by any person. Nothing contained herein or in any document incorporated herein shall be deemed to give any Employee or Participant the right to continue in the service of the Employer, to interfere with the right of the Employer to discharge any Employee or Participant at any time, or to give the Employer the right to require an Employee or Participant to remain in its service or to interfere with his right to terminate his service at any time.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

19.11 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine, or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

19.12 COMPLIANCE WITH FEDERAL MANDATES

The Plan will comply, to the extent applicable, with the requirements of all applicable laws (as amended), including but not limited to the Uniform Services Employment and Reemployment Rights Act of 1974 (USERRA); Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); Health Insurance Accountability and Portability Act of 1996 (HIPAA); Newborns' and Mothers' Health Protection Act of 1996 (NMHP); Women's Health and Cancer Rights Act of

1998 (WHCRA); Mental Health Parity Act (MHPA); and Family and Medical Leave Act of 1993 (FMLA). With respect to any self-insured group health benefits that are provided under this Plan, the County may elect to not comply with the health care portability provisions of HIPAA, with NMHP, and/or WHCRA, provided the County complies with the applicable opt-out requirements as allowed under those laws.

19.13 SEVERABILITY

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

19.14 CAPTIONS

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

19.15 CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

19.16 GOVERNING LAW

The Plan is governed by the Internal Revenue Code of 1986, the Public Health Service Act, and the regulations issued thereunder (as they might be amended from time to time). To the extent not preempted by Federal law, the provisions of the Plan shall be construed, administered, and enforced according to the laws of the Commonwealth of Virginia without regard to its conflict of law rules.

SECTION 20
IMPORTANT PHONE NUMBERS

Member Services
Standard POS, Premier POS, and KeyCare PPO: 1-800-451-1527
Lumenos with HSA: 1-800-582-6941

24/7 NurseLine
Standard POS, Premier POS, and KeyCare PPO: 1-800-337-4770
Lumenos HSA: 1-866-800-8780

BlueCard Acess (for information while traveling out of state)
1-800-810-2583

Guest Membership
Standard POS, Premier POS, and Lumenos HSA: 1-866-823-5391

Provider Services (if doctor needs to contact Claims Administrator to coordinate a service for a participant or obtain an authorization)
1-800-533-1120

Pre-Authorization (for members who choose to go out of network)
1-800-533-1120

Mental Health Services (for services requiring pre-authorization)
1-800-991-6045

American Specialty Health Group (ASHG)
Standard POS, Premier POS, and Lumenos HSA:
800-972-4226 (questions about ASHG providers)
800-678-9133 (questions about coverage)

EXHIBIT A EXPERIMENTAL/INVESTIGATIVE CRITERIA

Experimental/Investigative Criteria
Experimental/Investigative means any service or supply that is judged to be experimental or investigative at the Claims Administrator's sole discretion. Nothing in this exclusion shall prevent a participant from appealing the decision that a service is Experimental/Investigative. Services which do not meet each of the following criteria will be excluded from coverage as Experimental/Investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.
   a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
      • the following three standard reference compendia defined below:
         1) American Hospital Formulary Service – Drug Information
         2) National Comprehensive Cancer Network's Drugs & Biologics Compendium
         3) Elsevier Gold Standard's Clinical Pharmacology
      • in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or
   b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

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

2. There must be enough information in the peer-reviewed medical and scientific literature to let the Claims Administrator judge the safety and efficacy.

3. The available scientific evidence must show a good effect on health outcomes outside a research Setting.

4. The service or supply must be as safe and effective outside a research *Setting* as current diagnostic or therapeutic options.

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

Clinical trial costs
Clinical trial cost means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer where all of the following circumstances exist:

1) The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial;
2) Treatment provided by a clinical trial is approved by:
   • The National Cancer Institute (NCI);
   • An NCI cooperative group or an NCI center;

- The U.S. Food and Drug Administration in the form of an investigational new drug application;
- The Federal Department of Veterans Affairs; or
- An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI;

3) With respect to the treatment provided by a clinical trial:
   - There is no clearly superior, non-investigational treatment alternative;
   - The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and
   - The Covered Person and the physician or health care Provider who provides the services to the Covered Person conclude that the Covered Person's participation in the clinical trial would be appropriate; and
4) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

"Patient cost" under this paragraph means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Covered Person for purposes of a clinical trial. "Patient cost" does not include (i) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

APPENDIX A CLAIMS ADMINISTRATOR

Effective January 1, 2015

This Appendix A is attached to, forms a part of, and is incorporated by reference into the plan document for the County of Henrico (the "Plan"). The words, terms and phrases used herein shall have the same meaning as those defined in and used in the Plan. As of the date of the restatement of the Plan, including this Appendix A, by the County, the third-party administrator contracted to process claims and administer the day-to-day operations of the Plan is as follows:

Anthem Blue Cross Blue Shield

Mailing Address
P. O. Box 26623
Richmond, VA 23261-0031

Member Services

Standard POS and Premier POS: 1-800-421-1527
Lumenos HSA: 1-866-800-8780
Monday through Friday 8:00 a.m. to 6:00 p.m.

www.anthem.com