Anthem

Community Insurance Company
1351 Wm Howard Taft
Cincinnati, OH 45206

Prescription Drug

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

Senior Rx Plus

This Plan supplements benefits paid by the Group Part D plan you also have through the Retiree's former employer. The benefits provided by this plan never duplicate benefits provided under the Group Part D plan.

Please Read Your Booklet Carefully

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

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Introduction

This plan is offered by Anthem Blue Cross and Blue Shield (Anthem), referred to throughout the Booklet as "we," "us" or "our." Senior Rx Plus is referred to as "plan" or "your plan."

This Booklet (sometimes called Evidence of Coverage) is the legal document explaining your coverage. Please read this Booklet carefully and refer to it whenever you require Prescription Drug services.

This Booklet explains many of the rights and obligations between you and us. It also describes how to obtain prescription drug services, what prescription drugs are covered and not covered, and what portion of the prescription drug costs you will be required to pay. Many of the provisions in this Booklet are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. We encourage you to set aside some time to look through this Booklet. You are responsible for knowing the terms of this Booklet.

The coverage described in this Booklet is based upon the conditions of the Group Contract issued to the retiree's former employer, and is based upon the benefit plan that your Group chose for you. The Group Contract, Group Application, this Booklet, and your Application form the Contract under which Covered Services are available under your prescription drug benefits.

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

If you have any questions about your plan, please call the Member Services number located on the back of your Plan Membership Card (sometimes called Identification Card).

How to obtain language assistance

Anthem is committed to communicating with our members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our Member Services Call Centers. Simply call the Member Services phone number on the back of your plan membership card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services.

> Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.
> (If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the Member Services number.)

This non-Medicare drug plan supplements benefits paid by the Group Medicare Part D Prescription Drug plan (also known as Group Part D plan), which you also have as part of the group retiree benefits offered by the retiree's former employer. Your Group Part D plan may be a stand-alone drug plan (Part D only plan) or combined with your Medicare medical coverage (Medicare Advantage Prescription Drug plan). Please see the "Outpatient Prescription Drug Benefits" and "Coordination of Benefits" sections of this Booklet for more information about how this plan supplements your Group Part D plan.

Jane Peterson
President, Ohio

Table of Contents

Benefits Chart

This Benefits Chart (sometimes called Schedule of Benefits) describes the costs you must pay after benefits are provided under this Certificate and your Group Part D plan. For a more detailed explanation of the benefits provided, please refer to the appropriate sections of this Certificate.

Benefit Period	**January 1, 2025 – December 31, 2025**	
Formulary	**Closed**	
Deductible	**$0**	
Covered Services	**What you pay**	
Part D Covered Drugs		
After benefits have been paid by your Group Part D plan and this plan for covered drugs, you will be responsible for the amounts shown below.		
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)	
	Preferred Network Pharmacy	Standard Network Pharmacy
• Select Generics	$0 copay	$0 copay
• Preferred Generics	$5 copay	$12 copay
• Generics	$15 copay	$20 copay
• Preferred Drugs	$40 copay	$47 copay
• Non-Preferred Drugs	50% coinsurance	50% coinsurance
• Specialty Drugs	33% coinsurance	33% coinsurance

Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will only need to pay two copays.

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay
• Preferred Generics	$10 copay
• Generics	$30 copay
• Preferred Drugs	$80 copay
• Non-Preferred Drugs	50% coinsurance
• Specialty Drugs	33% coinsurance

- Your retiree drug plan has a large nationwide retail pharmacy network, plus mail-order pharmacies for convenient home delivery. When you want to use a retail pharmacy, you will save on most fills if you choose to use one of the network's preferred retail pharmacies. Preferred retail pharmacies are identified in your Group Medicare prescription drug plan's pharmacy directory.

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Outpatient Prescription Drug Benefits

For most covered drugs, this plan supplements the benefits paid by the Group Part D plan you also have through the retiree's former employer. This section describes the benefits available under this plan.

Your Group Part D plan is the primary payer plan for all covered Medicare Part D-eligible drugs and this plan will supplement benefits provided by that plan in the form of reduced cost sharing. If your Group Part D plan covers a Medicare Part D-eligible drug, then this plan will supplement benefits paid by your Group Part D plan up to, but not including, the Deductible, Coinsurance or Copay (Copayment) amounts shown in this plan's benefits chart. If your costs change during the Group Part D plan's Gap phase, the **"Part D Covered Drugs"** section of this plan's benefits chart will describe the cost you pay during the Part D Gap phase.

All outpatient drugs covered under the **"Extra Covered Drugs"** benefit, as outlined in the benefits chart in the front of this Booklet, will be covered only by this plan.

No deductible applies to the **"Extra Covered Drugs"** benefits provided by this plan.

Most drugs covered under your retiree drug plan are covered first by the Group Part D plan. For Part D-eligible drugs the Group Part D plan will pay first and will determine whether a drug you are taking will be covered or whether coverage will be subject to any restrictions. When this supplemental plan provides benefits for **"Extra Covered Drugs"** not covered by the Group Part D plan, this plan will determine whether a drug you are taking is covered. If you have a quantity limit on an **Extra Covered Drug**, the limit will show in the "**Benefits Chart**" in the front of this Booklet. You have the right to appeal a quantity limit as described in the **"Complaint and Appeals Procedures"** chapter of this Booklet.

Coinsurance/Copayment

The coinsurance or copayment amount shown in the benefits chart in this Booklet is the amount you will have to pay for covered drugs after your Group Part D plan and this plan have paid benefits and you have met your deductible, if you have one. A separate coinsurance or copayment will apply to each covered drug that you fill when you go to a Pharmacy. When you owe a flat copayment, your prescription drug copayment will be the lesser of your plan's copayment amount or the Maximum Allowable Amount for the covered drug.

Tiers

Your coinsurance or copayment amount may vary based on the tier in which your drug is covered. The determinations of which tier a drug will be on is made by us based upon clinical information, and where appropriate the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition and the availability of over-the-counter alternatives.

Each of your drug plan tiers has a tier label which lists the types of drugs covered in that tier and a tier number. The benefit charts in the front of this Booklet shows the tier label with its respective copay, and the Group Part D plan and Senior Rx Plus *Drug List (Formulary)* shows the tier number for each drug. The *Drug List (Formulary)* also includes a small chart which lists the tier label for each tier number.

We'll provide you a copy of the *Drug List (Formulary)* each year. You may also get the most complete and current information about which drugs are covered by calling Member Services at the number on the back of your plan membership card or by visiting your plan's website www.anthem.com.

How to Obtain Prescription Drug Benefits

Your plan membership card covers both your Group Part D plan and this plan. Just give the pharmacist your plan membership card when you get your prescription filled or complete the mail order request form you received with your new member materials. You will need to answer some basic questions about yourself and send us your written prescriptions with your first mail order request. You may also call Member Services at the number on the back of your plan membership card to get a mail order request form. We will process benefits under your Group Part D plan and/or this plan automatically when you use a participating pharmacy. So long as your drug is covered under your Group Part D plan or your Senior Rx Plus plan, you do not need to take any additional steps.

If you receive outpatient drugs from a pharmacy that does not have a contract with us, you will need to pay the full cost of your outpatient drug(s). You can ask us to reimburse you for our share of the cost.

Please send us your request for payment. Your request should include your name and address, your plan membership number, your receipt documenting the outpatient drug(s) you received, and the payment you have made. It's a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment. You don't have to use the form, but it's helpful for your plan to process the information faster.

Mail your request for payment together with any receipts to us at this address:

Senior Rx Plus
Attn: Claims Department - Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

If you need assistance or have any questions, please call Member Services at the number listed on the back of your plan membership card. If you don't know what you owe, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

Non-Covered Services/Exclusions

This plan supplements the benefits paid by the Group Part D plan you also have through the retiree's former employer. This plan may also provide coverage for drugs offered under the **"Extra Covered Drugs"** benefit.

This plan does not provide benefits for:

1. Drug costs not covered by your Group Part D plan, except costs for drugs covered under the **"Extra Covered Drugs"** benefit.
2. Drugs covered under Medicare Part A or Part B, unless these are listed in the **"Extra Covered Drugs"** section of the benefits chart in the front of this Booklet.
3. Costs you pay toward meeting your deductible, if you have one.
4. Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

These categories of drugs are not covered by this plan unless your plan covers them as **"Extra Covered Drugs."** Please see the **"Extra Covered Drugs"** list in the benefits chart located in the front of this Booklet to find out which of the drug groups listed below are covered under your plan.

1. Drugs when used to promote fertility.
2. Drugs when used for the relief of cough or cold symptoms.
3. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
4. Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra and Caverject.
5. Non-prescription drugs (also called over-the-counter drugs).
6. Drugs when used for treatment of anorexia, weight loss or weight gain, unless used to treat HIV and cancer wasting.
7. Drugs when used for cosmetic purposes or to promote hair growth.

Coordination of Benefits when Members Are Insured Under More Than One Plan

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

The order of benefit determination rules governs the order in which each plan will pay a claim for benefits. The plan that pays first is called the Primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the Secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Definitions

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

   (1) Plan includes: group and non-group insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

C. The order of benefit determination rules determines whether this plan is a Primary plan or Secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider

by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers which have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

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

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

B. (1) Except as provided in Paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed

over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

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

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

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

iii. However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent;
- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then

- The plan covering the spouse of the non-custodial parent.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Anthem may get the facts we need from them or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Anthem need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Anthem any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at the number on the back of your plan membership card. Follow the steps described in the **"Complaint and Appeals Procedures"** section of the Booklet. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526 or visit the Department's website at http://insurance.ohio.gov.

Eligibility and Enrollment

You must satisfy certain requirements to participate in this plan. We describe general eligibility requirements in this Booklet. Please contact your Human Resources or Benefits department if you have questions regarding your or your Dependent's eligibility for the group retiree benefit plan options offered by the retiree's former employer.

Eligibility

To be eligible to enroll under this Booklet, you must:

- Be a retiree or dependent of the retiree of the group.
- Be entitled to participate in the retiree benefit plan arranged by the group.
- Be entitled to Medicare Part A and/or enrolled in Medicare Part B.
- Be enrolling in or enrolled in the Group Part D plan (Part D or Medicare Advantage Prescription Drug plan) that is also part of the group retiree benefit plan arranged by the retiree's former employer for Medicare-eligible retirees and their Medicare-eligible dependents.
- Live in the service area in which we can provide retired group members access to participating pharmacies. Our service area includes the 50 United States, District of Columbia (DC) and all U.S. Territories.
    - We cannot service retirees or their dependents if they live outside our service area. If you plan to move out of the service area, please contact Member Services or your Human Resources or Benefits department.

Subject to meeting all the eligibility provisions listed in this **"Eligibility"** section, Medicare-eligible dependent children who may be eligible to enroll in this plan include:

- The Covered Retiree's or the covered retiree's spouse's children, including natural children, stepchildren, and legally adopted children and children who the group has determined are covered under a "Qualified Medical Child Support Order (QMCSO)" as defined by ERISA or any applicable state law.
- Children for whom the covered retiree or the covered retiree's spouse is a legal guardian or as otherwise required by law.
- At the covered retiree's request, eligibility will be continued past the age limit until the end of the calendar year month in which the dependent child reaches age 28, if the child:
    - Is the natural child, stepchild or adopted child of the covered retiree.
    - Is a resident of Ohio or a full-time student at an accredited higher education institution.
    - Is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.
    - Is not eligible for coverage under Medicaid or Medicare.

This non-Medicare retiree drug plan is part of the group retiree benefit plan offering for retirees and their dependents that are Medicare-eligible. Please contact your Human Resources or Benefits department if you need information on group retiree benefit plan options for yourself or your dependents who are not Medicare-eligible.

Enrollment
An eligible retiree or dependent must meet all eligibility requirements to enroll.

Initial Enrollment
An eligible retiree or dependent can enroll for coverage under this Booklet when they first become eligible for this plan. You must submit your completed application for enrollment. You can enroll in this plan when you are first eligible if you are already enrolled in or are concurrently enrolling in the Group Part D plan that is also part of the group retiree benefit plan arranged by the retiree's former employer for Medicare-eligible retirees and their Medicare-eligible dependents.

If you do not enroll when you are first eligible, you can only enroll for coverage during a Special Enrollment period or during an Open Enrollment period, if the retiree's former employer offers an annual open enrollment opportunity. Please contact your Human Resources or Benefits department if you need information on the timeframes in which to enroll.

When the initial enrollment application is accepted, coverage will begin on the Effective Date requested on the application or the first of the month following acceptance of the application, whichever comes later. The effective date of this plan may not be prior to the effective date of the Group Part D plan which this plan supplements.

This non-Medicare retiree drug plan is part of the group retiree benefit plan offering for retirees and their dependents that are Medicare-eligible. Please contact your Human Resources or Benefits department if you need information on group retiree benefit plan options for yourself or your dependents that are not Medicare-eligible.

Special Enrollment/Special Enrollees
If you meet all the eligibility requirements listed in this Booklet but did not enroll in this plan because of other health insurance coverage, you may in the future be able to enroll in this plan provided that you submit a completed application within 31 days after other coverage ends.

In addition, if a covered retiree has a new Medicare-eligible dependent as a result of marriage, adoption or placement for adoption, the new dependent may be able to enroll in this plan, provided that a completed application is submitted within 31 days after the marriage, adoption or placement for adoption and the dependent meets all the other eligibility requirements listed in this Booklet.

When a special enrollment application is accepted, coverage will begin on the effective date requested on the application or the first of the month following acceptance of the application, whichever comes later. The effective date of this plan may not be prior to the effective date of the Group Part D plan which this plan supplements.

Open Enrollment
Some group retiree benefit plans offer an annual open enrollment period. An open enrollment period is a period of time when an eligible retiree or dependent who did not request enrollment for coverage during their initial enrollment period or a special enrollment period can apply for coverage.

Please contact your Human Resources or Benefits department to find out whether your group retiree benefit plan offers open enrollment periods.

When an open enrollment application is accepted, coverage will begin on the effective date requested on the application or the first of the month following acceptance of the application,

whichever comes later. The effective date of this plan may not be prior to the effective date of the Group Part D plan which this plan supplements.

Notice of Changes

The covered retiree is responsible to notify the group of any changes which will affect his or her eligibility or that of dependents for services or benefits under this Booklet. The plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare plan. Failure to notify us of persons no longer eligible for services will not obligate us to pay for such services.

Acceptance of payments from the group for persons no longer eligible for services will not obligate us to pay for such services.

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

A member's coverage terminates on the last day of the month in which the member ceases to be in a class of members eligible for coverage. The plan has the right to bill the covered retiree for the cost of any services provided to such person during the period such person was not eligible for coverage.

Nondiscrimination

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

Statements and Forms

The eligible retiree or dependent must complete and submit their applications for this plan which is part of the group retiree benefit plan offering for retirees and their dependents who are Medicare-eligible.

Any rights to benefits under this plan are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a member may result in termination of coverage as provided in the **"Changes in Coverage: Termination & Continuation of Coverage"** section.

Delivery of Documents

We will provide a plan membership card and Booklet for each enrolled member.

Please carry your plan membership card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost or stolen, call Member Services right away and we will send you a new plan membership card.

Changes in Coverage: Termination & Continuation of Coverage

Termination of the Member

The member's enrollment in this plan shall terminate:

1. The date the group contract with us terminates.
2. On the date stated in the notice mailed by us to the group contract holder if we do not receive the group contract holder's Premium on time. Your payment of charges to the group contract holder does not guarantee coverage unless we receive full payment when due. If the premium is not paid on time, we will not make any payments for any service given to you after the plan terminates.
3. The date that coverage under the Group Part D plan which this plan supplements ends, whether you voluntarily or involuntarily terminate your Group Part D plan.
4. If the group offers an open enrollment period for retiree benefits, the covered retiree may voluntarily terminate coverage effective as of the renewal date of the group retiree benefit plan.
5. The day following the covered retiree's death. When a covered retiree dies, dependents shall be terminated the last day of the month in which the covered retiree died, unless the group retiree benefit plan allows dependents to remain enrolled.
6. The last day of the month in which the covered retiree or dependent no longer meets the eligibility requirements of the retiree drug plan as defined in the **"Eligibility"** section of this Booklet.
7. When a member ceases to be a covered retiree or dependent, or the required contribution, if any, is not paid, the member's coverage will terminate the last day of the month for which payment was made.
8. Termination of an enrolled dependent's coverage will occur on the last day of the month in which one of the following events occurs:
    - Divorce or legal separation of the spouse.
    - Other enrolled dependents' criteria are no longer met by the spouse or enrolled dependents as defined in the **"Eligibility"** section.
    - Death of an enrolled dependent.
9. Upon written request through the group, a covered retiree may cancel the enrollment of any dependent from the plan. If this happens, no benefits will be provided for covered services provided after the dependent's termination date.
10. If the covered retiree or dependent lets someone else use the plan membership card to get prescription drugs.
11. On the date stated in the notice mailed by us to you if we do not receive your direct-billed portion of the premium on time. If the premium is not paid on time, we will not make any payments for any service given to you after the plan terminates.

Consent

No event of termination, expiration, non-renewal or cancellation of this retiree drug plan shall affect the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of any such event. The member hereby acknowledges that the termination, expiration, non-renewal or cancellation of the contract will automatically result in the termination of this retiree drug plan.

Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time your or the group's request for reinstatement is being considered by us. Your coverage shall not be adversely affected due to the group's clerical error. However, the group is liable to us if we incur financial loss as a result of the group's clerical error.

Continuation of Coverage

Federal Continuation of Coverage (COBRA)

If you or your covered dependents no longer qualify for coverage under this plan, you or your dependents may be eligible to continue group coverage under federal COBRA. Please contact your Human Resources or Benefits department for information on COBRA prior to coverage under this plan ending.

Complaint and Appeals Procedures

The following complaint and appeals process applies only to prescription drugs not covered by Medicare.

Our Member Services representatives are trained to answer your questions about your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including coinsurance and copayment amounts.
- Specific claims or services you have received.
- Pharmacies that participate with this plan.
- Provider directories.

Complaint and Appeal procedures have been established to provide fair, reasonable, and timely solutions to complaints that you may have concerning the plan. The plan invites you to share any concerns that you may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical providers in our networks.

The Complaint Procedure

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem or question about your plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your plan membership card. We will try to resolve your complaint informally by talking to your provider or reviewing your claim.

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

You will be notified of the resolution of your complaint if a claim or request for benefits is denied in whole or in part. We will explain why benefits were denied and describe your rights under the Appeal Procedure. If you are not satisfied with the resolution of your complaint, you have the right to file an Appeal, which is defined as follows:

Appeal Procedures

As a member of this plan, you have the right to appeal decisions to deny or limit your health care benefits. The explanation of why we denied your claim or request for benefits will describe the steps you should follow to initiate your appeal and how the appeal process works.

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

Internal Appeals

An initial determination by us can be appealed for internal review. The plan will advise you of your rights to appeal to the next level if a denial occurs after an initial determination.

You have the right to designate a representative (e.g., your physician) to file appeals with us on your behalf and to represent you in any level of the appeals process. If a representative is seeking an appeal on your behalf, we must obtain a signed Designation of Representation (DOR) form from you. The appeal process will not begin until we have received the properly completed DOR form except that if a physician request expedited review of an appeal on your behalf, the physician will

be deemed to be your designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form. We will forward a Designation of Representation form to you for completion in all other situations.

We will accept oral or written comments, documents or other information relating to an appeal from the member or the member's provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records and other information relevant to the member's appeal. If, after our determination that you are appealing, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal(s) decision(s) on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the appeal procedures outlined under this section, the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

To obtain information on our appeal procedures or to file an oral appeal please call the toll-free Member Services number listed on the back of your plan membership card or the number provided for appeals on any written notice of an adverse decision that you receive from us.

We will also accept appeals filed in writing. If you wish to file your appeal in writing, you must mail it to: Anthem Blue Cross and Blue Shield, Mailstop: OH0205-A537, 4361 Irwin Simpson Rd, Mason, OH 45040, or to the address provided for filing an appeal on any written notice of an adverse decision that you receive from us.

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

Standard Appeals

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

If you are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the appeal, we will provide you with a written response indicating our decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days from receipt of the appeal request. If more information is needed to make a decision on your appeal, we shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 45 calendar days of the appeal request, we shall conduct its review based upon the available information.

Appeal of an Adverse Pre-service Review/Prior Authorization Decision

If our decision regarding your pre-service review or prior authorization of a health care service, device, or drug submitted electronically by your provider is appealed, we will consider the appeal:

- Within 48 hours after the appeal is received if it's for urgent care services;
- Within 10 calendar days after the appeal is received for all other services if it's for non-emergency or non-urgent care services.

The appeal shall be between the provider requesting the service in question and a clinical peer.

If the appeal does not resolve the disagreement, either you or your authorized representative may request an external review as described in this section.

For purposes of this section only, urgent care services means medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of a pre service review request as outlined in the "Getting Approval For Benefits" section of this Booklet.

This section does not apply to Emergency services.

Once a Pre-service Review or Prior Authorization is approved, it will not be retroactively denied except in cases of fraudulent or materially incorrect information, or as otherwise provided under applicable state law.

Expedited Appeals

An expedited appeal may be initiated orally, in writing or by other reasonable means available to you or your provider. Given the urgent nature of an expedited appeal, we encourage you to request an expedited appeal orally. An expedited appeal is available only if the medical care for which coverage is being denied has not yet been rendered. We will complete expedited review of an appeal as soon as possible given the medical exigencies but no later than 72 hours after our receipt of the request and will communicate our decision by telephone to your attending physician or the ordering provider. We will also provide written notice of our determination to you, your attending physician or ordering provider, and the facility rendering the service.

You may request an expedited review for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
    1. Could seriously jeopardize your life or health or your ability to regain maximum function, or,
    2. In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a physician with knowledge of your medical condition determines is a claim involving urgent care.

Exhaustion of Internal Appeals Process

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

- We agree to waive the exhaustion requirement; or
- You did not receive a written decision of our internal appeal within the required time frame; or
- We failed to meet all requirements of the internal appeal process unless the failure:
    1. Was de minimis (minor);
    2. Does not cause or is not likely to cause prejudice or harm to you;
    3. Was for good cause and beyond our control;
    4. Is not reflective of a pattern or practice of non-compliance; or
- An expedited external review is sought simultaneously with an expedited internal review.

External Review

Definitions as used in the "External Review" section include the following:

"Adverse benefit determination" means a decision by a health plan issuer:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
    - A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
    - A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
    - A determination that a health care service is not a covered benefit;
    - The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To rescind coverage on a health benefit plan.

"Authorized representative" means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;

- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating health care professional, but only when the covered person is unable to provide consent.

"Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review.

"Covered benefits" or "benefits" mean those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Final adverse benefit determination" means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

"Health benefit plan" means a policy, contract, Booklet, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease.

"Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third-party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

"Independent review organization" means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

"Rescission" or **"to rescind"** means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

"Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
    - Serious impairment to bodily functions.
    - Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

"Superintendent" means the superintendent of insurance.

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by us to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO – A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person's health benefit plan, and the treating physician certifies at least one of the following:
  - Standard health care services have not been effective in improving the condition of the covered person.
  - Standard health care services are not medically appropriate for the covered person.
  - No available standard health care service covered by us is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The covered person's treating physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an adverse benefit determination of experimental or investigational treatment and the covered person's treating physician

certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance – A covered person is entitled to an external review by the Department in the either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The adverse benefit determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency, AND our decision has already been upheld through an external review by an IRO.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through us within 180 days of the date of the notice of final adverse benefit determination issued by us. All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however written confirmation of the request must be submitted to us no later than five days after the initial request. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete, we will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. We will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete, we will inform the covered person in writing and specify what information is needed to make the request complete. If we determine that the adverse benefit determination is not eligible for external review, we must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by us and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

When we initiate an external review by an IRO, the Ohio Department of Insurance web-based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with us, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by us in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by us of a request for a standard review or within 72 hours of receipt by us of a request for an expedited review. This notice will be sent to the covered person, us and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards that was used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on us except to the extent we have other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law. A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to us.

If You Have Questions About Your Rights or Need Assistance

You may contact us:

Anthem Blue Cross and Blue Shield
P.O. Box 173144
Denver, CO 80217-3144

To contact us by phone please call the number on back of your plan membership card.
Fax: 1-855-358-1226
Email: Ohio.Appeals@anthem.com

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD/TTY)
Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Appeal Filing Time Limit

We expect that you will use good faith to file an appeal on a timely basis. However, we will not review an appeal if it is received by us after 180 days have passed since the incident leading to your appeal.

Appeals by Members of ERISA Plans

If you are covered under a group plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file an appeal prior to bringing a civil action under 29 U.S.C. 1132§502(a).

General Provisions

Entire Contract
The laws of the state in which the group contract was issued will apply unless otherwise stated herein. This Booklet, the group contract, group application, and the individual applications of the covered retiree and dependents, if any, constitute the entire contract between the group and us and as of the effective date, supersede all other agreements. Any and all statements made to us by the group and any and all statements made to the group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet
No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

Assignment
The group cannot legally transfer this Booklet, without obtaining written permission from the plan. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any member without obtaining written permission from us, unless in a way described in this Booklet.

Confidentiality and Release of Information
Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

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

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

Not Liable for Provider Acts or Omissions
We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a provider of health care, services, or supplies.

Notice of Claim & Proof of Loss
Unless your prescription order is submitted to us electronically by the pharmacy, we must receive written notice that covered services have been given to you. After you get covered services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get covered services will be denied** except in the case of fraud by a provider.

Explanation of Benefits (EOB)

The month after you receive your prescription drugs, you will receive an *Explanation of Benefits (EOB)*. The *EOB* is a summary of the coverage you receive. The *EOB* is not a bill, but a statement from us to help you understand the coverage you are receiving. The *EOB* shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible, if any.
- General information about your appeals rights.

Workers' Compensation

The benefits under this Booklet are not designed to duplicate benefits that you are eligible for under the Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Booklet does not replace or affect any Workers' Compensation coverage requirements.

Other Government Programs

The benefits under this Booklet shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Plan Information Practices Notice

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

- We may collect personal information about a member from persons or entities other than the member.
- We may disclose member information to persons or entities outside of the plan without member authorization in certain circumstances.
- A member has a right of access and correction with respect to all personal information collected by us.

A more detailed notice will be furnished to you upon request.

Legal Action

You may not take legal action against us to receive benefits:

- Earlier than 60 days after we receive the claim; or
- Later than three years after the date the claim is required to be furnished to us.

Right of Recovery

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

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

Relationship of Parties (Group Member Plan)

The group is responsible for passing information to you. For example, if we give notice to the group, it is the group's responsibility to pass that information to you. The group is also responsible for passing eligibility data to us in a timely manner. If the group does not provide us timely enrollment and termination information, we are not responsible for the payment of covered services for members.

Contract with Anthem

The group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Booklet constitutes a contract solely between the group and us, Community Insurance Company dba Anthem Blue Cross and Blue Shield (Anthem), and that we are is an independent corporation licensed to use the Blue Cross Blue Shield names and marks in the state of Ohio. The Blue Cross Blue Shield marks are registered by the Blue Cross Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this contract based upon representations by any person other than Community Insurance Company and that no person, entity, or organization other than Community Insurance Company shall be held accountable or liable to the group for any of Community Insurance Company's obligations to the group created under this Booklet. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Modifications

This Booklet allows the group to make the plan coverage available to eligible members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the group contract or by mutual agreement between the group and us without the permission or involvement of any member. Changes will not be effective until the date specified in the written notice we give to the group about the change. By electing coverage under the plan or accepting the plan benefits, all members who are legally capable of entering into a contract, and the legal representatives of all members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Booklet.

Conformity with Law
Any provision of this plan which is in conflict with the laws of the state in which the group contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Clerical Error
A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of this Booklet. This rule applies to any clerical error, regardless of whether it was the fault of the group or us.

Reservation of Discretionary Authority
This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment or supplies are Medically Necessary, Experimental/Investigative, and whether charges are consistent with the maximum allowable amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Booklet. This includes, without limitation, the power to construe the contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Booklet. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the contract, the Booklet, provider agreements and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Unauthorized Use of Plan Membership Card
If you permit your plan membership card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value of Covered Services
For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of covered services shall be the amount we paid for the covered services.

Waiver
No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Definitions

Some words or phrases in this Booklet have special meaning. If the word or phrase is not explained in the text where it appears, it will be defined in this section.

If you need additional clarification on any of these definitions, please contact Member Services at the number located on the back of your plan membership card.

Benefit Period – The length of time that we will pay benefits for covered services. The benefit period is listed in the benefits chart. If your coverage ends before this length of time, then the benefit period also ends.

Booklet (also called Certificate or Evidence of Coverage) – The document providing a summary of the terms of your benefits. It is attached to, and is a part of, the group contract. It is also subject to the terms of the group contract.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Generic drugs are manufactured and sold by other drug manufacturers and are not available until after the patent on the brand name drug has expired.

COBRA – Sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as amended) that regulate conditions in which an employer must offer continuation of group health insurance coverage to members whose coverage would terminate based upon the terms of the group contract.

Coinsurance – A specific percentage of the maximum allowable amount for covered services that are indicated in the benefits chart, which you must pay.

Copayment – A specific dollar amount of the maximum allowable amount for covered services that are indicated in the benefits chart, which you must pay. Your copayment will be the lesser of the amount shown in the benefits chart or the amount charged by the provider.

Covered Drugs (also called Covered Services) – The term we use to mean all of the outpatient prescription drugs covered by your plan.

Covered Retiree – A retiree of the group who is eligible to receive benefits under the group contract, who has applied for coverage, been approved by the plan and been covered by the required premium payment.

Dependent – A member of the retiree's family who is eligible to be covered under the Booklet, as described in the **"Eligibility and Enrollment"** section.

DESI – Drug Efficacy Study Implementation (DESI) review. Drugs entering the market between 1938 and 1962 that were approved for safety but not effectiveness are referred to as "DESI drugs."

Effective Date – The date that a member's coverage begins under this Booklet.

Extra Covered Drugs – Is used to describe coverage of drugs which are excluded by law from coverage by Medicare Part D but are included in some retiree drug plans. If your plan covers drugs under the **"Extra Covered Drugs"** benefit, these will be listed in the benefits chart located in the front of this Booklet.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Most of the time generic drugs cost less than brand name drugs.

Group – The employer or union that has entered into a group contract with the plan.

Group Contract (Contract) – The Contract between the plan and the group. It includes the group contract, group application, this Booklet and your application.

Group Medicare Prescription Drug Plan (Group Medicare Part D Plan, Group Part D Plan) – Medicare Prescription Drug plan sold to employers or unions as a retiree benefit plan offered to their Medicare-eligible retirees and the retiree's Medicare-eligible dependents. See also **"Medicare Prescription Drug Plan"** definition.

Lifestyle Drug – Drug that is taken to improve quality of life as opposed to a drug taken to cure or manage an illness. Under this Booklet, lifestyle drugs include drugs to treat erectile dysfunction or vaginal dryness. Not all plans cover these drugs. Please check the benefits chart in the front of this Booklet to see if your plan includes this coverage.

Maximum Allowable Amount – The maximum allowed amount for covered prescription drugs is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

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

- Place the health of an individual, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities and people with end-stage renal disease (usually those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage plan.

Medicare Advantage Plan – A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (hospital) and Part B (medical) benefits. Medicare Advantage plans which also offer Medicare Part D (prescription drug coverage) are called Medicare Advantage Prescription Drug plans.

Medicare Part D-eligible (referred to as "Medicare-eligible" in this Booklet) – An individual is eligible to enroll in a Medicare Part D plan if the individual is entitled to Medicare Part A and/or enrolled in Medicare Part B.

Medicare Part D-eligible Drug – Subject to certain exclusions, a Medicare Part D-eligible drug is a drug dispensed only upon a prescription, used for a medically-accepted indication, approved by the Food and Drug Administration (FDA), and used and sold in the United States. Medicare Part D-eligible drugs include outpatient prescription drugs, biological products, insulin, medical supplies associated with the injection of insulin and certain vaccines.

Medicare Prescription Drug Plan (Medicare Part D Plan, Part D Plan) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals and some supplies not covered by Medicare Part A or Part B. Medicare prescription drug plans are available as stand-alone plans or coupled with the Medicare Advantage medical plans.

Member – A covered retiree or dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the plan and been covered by the required premium payment. Members are sometimes called "you" or "your" in this Booklet.

Open Enrollment – A period of enrollment designated by the retiree's former employer and the plan in which eligible retirees or their eligible dependents can enroll without penalty after the initial enrollment. See **"Eligibility and Enrollment"** section for more information.

Participating Pharmacy (Network Pharmacy) – A pharmacy which has contracted with us to provide outpatient prescription drugs to our members at negotiated costs.

Pharmacy – An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a physician's order.

Pharmacy and Therapeutics (P&T) Committee – A committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Plan Membership Card (also called Identification Card/ID Card) – A card issued by the plan, showing the member's name and membership number which is used to access benefits for covered services.

Preferred Retail Pharmacy – A retail pharmacy which has contracted with us to provide outpatient prescription drugs to our members at reduced negotiated costs. Members pay a lower copay when they use one of these pharmacies. Please check the benefits chart in the front of this Booklet to see if your plan includes this coverage.

Premium – The charges that must be paid by the covered retiree or the group to maintain coverage.

Prescription Legend Drug (Prescription Drug or Drug) – A medicinal substance that is produced to treat illness or injury and is dispensed to outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under this Booklet.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Recovery – A Recovery is money you receive from another, their insurer or from any uninsured motorist, underinsured motorist, medical payments, no-fault or personal injury protection or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Recovery provisions of this plan.

Retiree – Former employee of the employer or member of a union who is entitled to participate in the retiree benefit plan arranged by the employer or union and who is enrolled in or enrolling in Medicare.

Select Generics – A specific list of generic drugs that have been on the market long enough to have a proven track record for effectiveness and value. A complete list of these drugs is included in your Group Part D and Senior Rx Plus *Drug List (Formulary)*. Some plans have reduced copayments for Select Generics. If your plan includes a reduced copayment, you can find this information listed on the benefits chart located in the front of this Booklet.

Service Area – The geographical area where we can provide convenient access to participating pharmacies, which includes the 50 United States, District of Columbia and all US Territories.

Special Enrollment – A period of enrollment in which certain eligible retirees or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, adoption, etc.

Tier – Every covered drug is in a specific cost sharing tier. Most of the time, the higher the cost sharing tier, the higher your cost for the drug.

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