WELS VEBA GROUP HEALTH CARE PLAN

SUMMARY PLAN DESCRIPTION

HIGH DEDUCTIBLE PLAN OPTION

EFFECTIVE DATE OF THE PLAN: JANUARY 1, 2020

Administered by
Anthem Insurance Companies, Inc.

The Third Party Administrator, Anthem Insurance Companies, Inc., provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If you need assistance in Spanish to understand this document, you may request it for free by calling customer service at the number on your Identification Card.

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HISTORY

The Wisconsin Evangelical Lutheran Synod (the "Synod") established a group medical plan for all Workers of the Synod and Workers in fellowship with the Synod. The Synod directed the Group Insurance Board of the Synod to formulate a specific plan. The Group Insurance Board proposed a group medical plan which was adopted by the 37th Biennial Synod Convention, August 7-14, 1963. The 47th Biennial Synod Convention directed the Group Insurance Board to investigate a change to a self-funded plan. The Group Insurance Board approved the establishment of a voluntary employees' beneficiary association ("VEBA"), described under section 501(c)(9) of the Internal Revenue Code (the "Code"), to provide, among other benefits, and to self-fund the Wisconsin Evangelical Lutheran Synod Group Medical Plan. This Wisconsin Evangelical Lutheran Synod Group Medical Plan became effective February 1, 1984. The Group Insurance Board has been replaced by the VEBA Commission, a representative body for the Synod and Workers that serves as the Plan Administrator. The Wisconsin Evangelical Lutheran Synod Group Medical Plan is now named the WELS VEBA Group Health Care Plan. This amended and restated document describes the group health High Deductible Plan Option available under the WELS VEBA Group Health Care Plan and is effective January 1, 2020. For purposes of this document, the WELS VEBA Group Health Care Plan High Deductible Plan Option is referred to as the "Plan." Other benefits that might be available under the WELS VEBA Group Health Care Plan are described in other summaries that will be provided to eligible Workers.

PURPOSE

The VEBA Commission maintains the WELS VEBA Group Health Care Plan to provide health and other welfare benefits for Workers and their families.

IMPORTANT INFORMATION

The Synod maintains this Plan for the exclusive benefit of Members. Although the Synod intends to maintain the Plan indefinitely, it retains the right to amend or terminate the Plan as provided herein. This Plan document determines the benefits a Member may receive. If you have any questions about the Plan, the VEBA Commission encourages you to contact the WELS Benefit Plans Office.

Note: For purposes of this Summary Plan Description, the words "you" and "your" refer to the term "Member" as defined in the "Definitions" section of the Plan.

THIRD PARTY ADMINISTRATOR

The WELS VEBA Group Health Care Plan has contracted with Anthem Insurance Companies, Inc. ("Anthem") for administrative services and Provider network contracting. Anthem has established the following Member Rights and Responsibilities with respect to Anthem's services.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You Have the Right to:

- Receive information about Anthem and its services, practitioners and Providers and Members' rights and responsibilities;
- Be treated respectfully, with consideration and dignity;
- Receive all the benefits to which you are entitled under the Plan;
- Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- Have a candid discussion with your Provider about treatment options, regardless of their cost or whether they are covered under the Plan;
- Participate with your Physician in decision making about your healthcare treatment;
- Refuse treatment and be informed by your Provider of the medical consequences;
- Receive wellness information to help you maintain a healthy lifestyle;
- Express concern and complaints about the care and services you received from a Provider, or the service you received from Anthem and to have Anthem on behalf of the Plan Administrator, investigate and take appropriate action;
- Appeal a claim decision as outlined in the "Benefit Claim Complaint & Appeals Procedures" section of this Summary Plan Description and to appeal a decision without fear of reprisal;
- Privacy and confidential handling of your information;
- Make recommendations regarding Anthem's rights and responsibilities policies; and
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

As a Member, You Have the Responsibility to:

- Understand your health issues and be wise consumers of health care services;
- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship;
- Provide complete and honest information we need to administer benefits and that Providers need to care for you;
- Follow the plan and instructions for care that you and your Provider have developed and agreed upon;
- Understand how to access care in routine, Emergency Care and urgent situations and to know your health care benefits as they relate to out-of-area coverage, Coinsurance, Deductibles, etc.;
- Notify your Provider or Anthem about concerns you have regarding the services or medical care you receive;
- Keep appointments for care and give reasonable notice of cancellations;
- Be considerate of other Members, Providers and Anthem's staff;

- Read and understand your Summary Plan Description and "Schedule of Benefits" and other materials from Anthem or the Plan Administrator concerning your health benefits;
- Provide accurate and complete information to Anthem, on behalf of the Plan Administrator, about other health care coverage and/or insurance benefits you may carry; and
- Inform the Plan Administrator of changes to your name, address, phone number or if you want to add or remove Dependents.

HOW TO OBTAIN COVERED SERVICES

Network Services and Benefits

If your care is rendered by a Network Provider, benefits will be provided at the Network level. Anthem is allowed by the Plan Administrator to determine whether services or supplies are Medically Necessary and to determine the Medical Necessity of the service or referral to be arranged.

Anthem, on behalf of the Plan Administrator, may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other Facility. This decision is made upon review of your condition and treatment.

If the type of Provider is not included in the Network, contact Anthem. Anthem, on behalf of the Plan Administrator, may approve a Non-Network Provider for that service as an Authorized Service. Network Providers are described below:

- **Network Providers** include Physicians, Professional Providers, Hospitals and Facility Providers who contract with Anthem to perform services for you.

  For services rendered by Network Providers:

  - you will not be required to file any claims for services you obtain directly from Network Providers. **Network Providers will seek compensation for Covered Services rendered from the Plan and not from you except for approved Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Plan.

  - Health Care Management is the responsibility of the Member.

Contact your Network Provider or Anthem to be sure that Prior Authorization and/or Precertification has been obtained.

Non-Network Services

Services, which are not obtained from a Network Provider or not an Authorized Service, will be considered a Non-Network Service. The only exceptions are Emergency Care and Urgent Care. In addition, benefit levels may differ for certain services if not obtained from a Network Provider**.**

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

- obtaining any Precertification which is required;
- filing claims; and
- higher cost sharing amounts.

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

Network Summary

A Member's Network Providers will be determined based upon where the Member lives and where he/she accesses care. For claims incurred in Wisconsin by Members who live in Wisconsin, the Network Providers are those Providers within the Blue Preferred Plus POS network. For claims incurred outside of Wisconsin by Wisconsin Members, the Network Providers are those Providers in the National Blue Card PPO network. For Members who live in any state other than Wisconsin, the Network Providers are those Providers within the National Blue Card PPO network for claims incurred in every state, including Wisconsin. Both the Blue Preferred Plus POS network and the National Blue Card PPO network are Blue Cross Blue Shield networks. Effective January 1, 2015, Providers providing internet or telephone consulting services through LiveHealth Online (online at http://www.livehealthonline.com/ or by phone at 855-603-7985) will be Network Providers for all Members.

You may obtain a list of Network Providers at no charge by contacting Anthem using the number on the back of your Identification Card.

Relationship of Parties (Anthem - Network Providers)

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

Neither Anthem nor the Plan Administrator shall be responsible for any claim or demand as a result of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

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

Not Liable for Provider Acts or Omissions

Neither Anthem nor the Plan Administrator is responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against Anthem and/or the Plan Administrator based on what a Provider of health care, services or supplies, does or does not do.

Identification Card

When you receive care from your Network Provider or other Provider, you must show your Identification Card. If you receive care through LiveHealth Online, you must register at LiveHealth Online, indicating that you participate in a plan administered by Anthem and providing your identification number from your Identification Card. Possession of an Identification Card confers no right to services or other benefits under the Plan. To be entitled to such services or benefits you must be a current Member. Any person receiving services or other benefits to which he or she is not then entitled under the provisions of the Plan will be responsible for the actual cost of such services or benefits.

SCHEDULE OF BENEFITS

The outline of benefits in this schedule is a summary of coverage provided by High Deductible Plan Option coverage under the WELS VEBA Group Health Care Plan. A detailed explanation of the benefits under this High Deductible Plan Option is provided in the pages which follow.

Benefits listed in the Plan are limited to the Maximum Allowable Amount and subject to the limitations and Exclusions specified in the Plan.

The Benefit Period for this Plan is a Calendar Year.

Comprehensive Medical Benefits

Individual Deductible Limit

$2,800.00 per person per Benefit Period

Family Deductible Limit

$5,600.00 per family per Benefit Period

Notes:

- The Deductible applies to all Covered Services and to Prescription Drug Benefits administered by Express Scripts, unless otherwise specified by the Plan.
- If a Covered Worker has *Employee plus Spouse Coverage, Employee plus Non-Spouse Beneficiary Coverage,* or *Family Coverage* for the Benefit Period, the family Deductible for that Benefit Period will apply. The family Deductible is an aggregate Deductible. This means any combination of amounts paid by the Covered Worker or his/her covered Dependents for expenses for Covered Services (and for eligible charges for prescription drugs under the Prescription Drug Benefits program administered by Express Scripts) incurred during the Benefit Period can be used to satisfy the family Deductible.* In no event, however, will the Deductible applicable to expenses for Covered Services (and for eligible charges for prescription drugs under the Prescription Drug Benefits program administered by Express Scripts) incurred during the Benefit Period for any individual Member exceed the individual Deductible.
- If a Covered Worker has *Employee Only Coverage,* only the individual Deductible will apply.
- The individual and family Deductible are subject to change each Benefit Period, based on the requirements established by the Internal Revenue Service (IRS). You will be notified if your Deductible changes.

Coinsurance Paid By The Plan

Unless otherwise specified, after satisfaction of the Deductible amount, eligible charges for Covered Services are covered at 80% (Network) or 70% (Non-Network), up to the Maximum Out-of-Pocket Amount specified by the Plan.

Maximum Out-of-Pocket Amounts

Unless otherwise specified, after satisfaction of the following Maximum Out-of-Pocket amounts, the Plan will cover eligible charges for Covered Services and eligible charges for prescription drugs under the Prescription Drug Benefits program administered by Express Scripts at 100% of the Maximum Allowable Amount for the remainder of that Benefit Period:

Per Individual	*Per Family*
$5,100	$10,200

Maximum Out-of-Pocket Amounts are combined for both Network and Non-Network Providers. These amounts include the Benefit Period Deductible amounts.

Amounts paid for, or applied to, the following will not be applied toward satisfaction of the Maximum Out-of-Pocket Amounts:

- penalty amounts; and
- charges not covered by the Plan.

Miscellaneous Benefits

Wellness Benefit

- The Deductible amount does not apply
- Amount paid by the Plan: 80% (Network) or 70% (Non-Network)
- Limited to a maximum of $300.00 per Benefit Period. Thereafter, the Benefit Period Deductible and Coinsurance amounts will apply.
- The following routine services are covered:

  examinations;

  pap smears;

  mammograms;

  other related x-ray and laboratory services;

  immunizations; and

  well-baby care.

  For care that constitutes Preventive Care, however, please see the coverage terms for Preventive Care.

Inpatient, Residential, Transitional (Partial/Intensive) and Outpatient Treatment of Mental Health and Substance Abuse

Inpatient Treatment of Mental Health

- Requires Precertification
- The Deductible and Coinsurance amounts apply

Inpatient Treatment of Substance Abuse

- Requires Precertification

- The Deductible and Coinsurance amounts apply

Residential Treatment of Mental Health

- Requires Precertification
- The Deductible and Coinsurance amounts apply

Residential Treatment of Substance Abuse

- Requires Precertification
- The Deductible and Coinsurance amounts apply

Transitional (Partial/Intense) Treatment of Mental Health

* Requires Precertification
* The Deductible and Coinsurance amounts apply

Transitional (Partial/Intense) Treatment of Substance Abuse

* Requires Precertification
* The Deductible and Coinsurance amounts apply

Outpatient Treatment of Mental Health and Substance Abuse

* The Deductible and Coinsurance amounts apply

Note: ADD/ADHD is covered.

Skilled Nursing Facility

- Requires Precertification
- The Deductible amount applies
- Amount paid by the Plan: 100%
- Limited to a maximum of 30 days per Benefit Period

Home Health Care

- The Deductible amount applies
- Amount paid by the Plan: 100%
- Includes Private Duty Nursing Services and Home Health Care Nursing Services through Home Care Services
- This benefit limited to nursing visits and does not include eligible charges for supplies, DME, home IV, and other Covered Services.
- Limited to a maximum of 50 visits per Benefit Period

Chiropractic Care

* The Deductible and Coinsurance amounts apply
* Limited to a maximum of 24 manipulative visits per Benefit Period

Therapy Services (Physical, Speech and Occupational)

- The Deductible and Coinsurance amounts apply
- Limited to a combined maximum of 40 visits per Benefit Period
- This benefit applies only when rendered as Physician's Office Services or Outpatient Facility Services

Note: If different types of Therapy Services are performed during one (1) Physician Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable maximum visits listed above. For example, if both a Physical Therapy Service and an Occupational Therapy Service are performed during one (1) Physician Office Service, or Outpatient Service, they will count as both one (1) Physical Therapy Visit and one (1) Occupational Therapy Visit.

Medical Supplies, Durable Medical Equipment and Appliances

- The Deductible and Coinsurance amounts apply
- Charges over $2,000.00 require Precertification
- Shoe inserts are covered only in conjunction with a bracing system

Orthoptic/Vision Therapy

- The Deductible and Coinsurance amounts apply
- Limited to a lifetime Maximum Benefit of one (1) initial examination and four (4) therapy sessions.

Maternity/Newborn Infant Charges

Eligible charges are covered subject to the Deductible and Coinsurance amounts for medical care in connection with pregnancy, childbirth or a related medical condition of a Member. This includes charges for three (3) ultrasounds per pregnancy. For care that constitutes Preventive Care, however, please see the coverage terms for Preventive Care.

Infertility Treatment

- The Deductible amount applies
- Amount paid by the Plan: 50% (Network or Non-Network)
- Limited to a lifetime Maximum Benefit of $5,000.00 per family.

Note: Does not include in-vitro and related services, artificial insemination, reversal sterilization, or surrogate maternity.

Sleep Studies

- The Deductible and Coinsurance amounts apply
- Limited to a maximum of 2 sleep studies per lifetime

Nutritional Counseling

- The Deductible and Coinsurance amounts apply

For care that constitutes Preventive Care, however, please see the coverage terms for Preventive Care.

Biofeedback Treatment

- The Deductible and Coinsurance amounts apply
- Limited to 10 sessions per Benefit Period

Hospice Services

- The Deductible and Coinsurance amounts apply

Diagnostic Services

- The Deductible and Coinsurance amounts apply

For care that constitutes Preventive Care, however, please see the coverage terms for Preventive Care.

Second Opinion (Voluntary and Health Care Management Request)

- If a Member is requested by Anthem Health Care Management or voluntarily seeks to obtain a second opinion for an Inpatient or Outpatient procedure, eligible charges for the second opinion examination and related services are covered at 100% and are subject to the Deductible amount.

Preventive Care

Preventive Care—Network Provider

- The Deductible and Coinsurance amounts do not apply*
- Amount paid by the Plan: 100%

Preventive Care—Non-Network Provider

- The Deductible and Coinsurance amounts will apply.

Anthem, on behalf of the Plan Administrator, reserves the right to use reasonable medical management techniques to determine the frequency, method, treatment or setting of Preventive Care.

Physician Office Services

- The Deductible and Coinsurance amount applies

For care that constitutes Preventive Care, however, please see the coverage terms for Preventive Care.

Allergy Services

- The Deductible and Coinsurance amount applies

Note: Sublingual drops not covered.

Inpatient Services

- Requires Precertification
- The Deductible and Coinsurance amounts apply

Outpatient Facility Services

- The Deductible and Coinsurance amounts apply

For care that constitutes Preventive Care, however, please see the coverage terms for Preventive Care.

Dental/Accident

- The Deductible and Coinsurance amounts apply

Note: Services must be rendered within 72 hours. Treatment must be completed within 12 months from the date of Injury.

Temporomandibular or Craniomandibular Joint disorder (TMJ)

- Requires Precertification
- The Deductible and Coinsurance amounts apply

Note: TMJ appliances not covered.

Emergency Room and Urgent Care Services

- The Deductible and Coinsurance amounts apply

Note: For Emergency Hospital Care provided by a Non-Network Provider, you are responsible for the same Coinsurance amounts that would have been imposed if the Emergency Hospital Care had been provided by a Network Provider.

Ambulance Services

- The Deductible amount applies
- Amount paid by the Plan: 100%

Human Organ and Tissue Transplant

Utilization of a Blue Quality Center for Transplants (BQCT) Facility

- The Deductible amount applies
- Amount paid by the Plan: 100%

Non-utilization of a BQCT Facility

- Network and Non-Network: The Deductible and Coinsurance amounts apply*

***Please Note:** Charges incurred by the donor with a Non-Network provider will

not be covered. Eligible donor charges may be covered by the Plan only if a BQCT Facility and/or Network Hospital are used. Additional information may be found under the Covered Services section of the Plan.

Eligible Prescription Drugs

- The Deductible amount applies
- Amount paid by the Plan: 100%
- Retail program dispensing limitation: Not to exceed a 30 day supply
- Mail order program dispensing limitation: Not to exceed a 90 day supply

Note: Eligible prescription drug expenses will initially be applied to Deductible until the Deductible is met.

Note: Eligible prescription drug expenses that Medicaid pays on behalf of a Member may be covered by the Plan. Please contact the Plan Administrator for coordination of benefits.

Maximum Lifetime Benefits

The Plan does not impose a general Maximum Lifetime Benefit. The Plan does, however, impose Maximum Lifetime Benefits on the following non-essential health benefits:

- Orthoptic/Vision Therapy- limited to 1 initial exam and 4 therapy sessions while covered by the Plan
- Infertility Treatment – limited to $5,000.00 per family
- Sleep Studies – limited to 2 sleep studies per person per lifetime

ELIGIBILITY, ENROLLMENT, TERMINATION, CONTINUATION AND CONVERSION

ELIGIBILITY FOR COVERAGE

ELIGIBILITY PROVISIONS

Eligible Workers

- A Worker is eligible to participate in the Plan as of the Worker's Date of Employment.

PLAN ENROLLMENT

A. Initial Enrollment Period

To enroll for health benefits under this Plan, a Worker must submit an appropriately completed enrollment application to the Plan Administrator through the WELS Benefits Service Center website (www.wels.bswift.com) no later than the 60th day following the Worker's Date of Employment. A Worker may also enroll by contacting the WELS Benefits Service Center by telephone at 1-800-487-8322, or by email at wels@bswift.com. For more information regarding enrollment, contact the WELS Benefits Service Center at 1-800-487-8322. The Worker may enroll (i) the Worker, or (ii) the Worker and his/her Dependent(s) by selecting an appropriate Coverage Option and completing the associated enrollment materials.

If a Worker timely enrolls for Plan coverage under this Section A, Plan coverage will be effective on the latest of the following dates:

1. The Worker's Date of Employment at an eligible Sponsoring Organization;

2. The date the Plan Administrator receives the timely completed and submitted enrollment application; or,
3. The effective coverage date requested by the Worker, provided that date is no later than 60 days after the earlier of 1 or 2 above.

B. Enrollment Application

In the enrollment application, the Worker must select coverage under this Plan (and select a Coverage Option) or the Basic Plan Option (the enrollment rules for which are described in a separate document). The Coverage Option selected will determine the following: the applicable Deductible(s) and maximum out-of-pocket; which of the Worker's Dependents, if any, are covered; and, (when considered in conjunction with the billing region) the cost of the Worker's coverage.

C. Special Enrollment Provisions

A Worker who is not enrolled for health benefits under the WELS VEBA Group Health Care Plan (whether under this Plan or the Basic Plan Option) for himself/herself or for any of his/her Dependents may enroll for coverage as described in this Section C.

1. ***Loss of Coverage***

If the Worker and/or Dependent:

- Had coverage under another health plan (or health insurance) that was COBRA Coverage and the COBRA Coverage has been exhausted; or

- Had coverage under another health plan (or health insurance) that was not COBRA Coverage and that Creditable Coverage has been lost due to Loss of Eligibility for that coverage, termination of Employer contributions toward that coverage, or exhaustion of COBRA Coverage (if elected); then

the Worker may enroll for health benefit coverage under the WELS VEBA Group Health Care Plan (whether under this Plan or the Basic Plan Option) for (a) the Worker, or (b) the Worker (i.e., if not already a Member) and his/her Dependents. For purposes of this subsection 1, "coverage under another health plan (or health insurance)" means coverage under a health program that would constitute Creditable Coverage.

a) ***Procedure.*** To enroll, the Worker must submit an appropriately completed enrollment application to the Plan Administrator through the WELS Benefits Service Center, as described under Section A "Initial Enrollment Period" above, within 60 days after the Worker and/or Dependent has exhausted or lost coverage as described above. (In the case of a Loss of Eligibility that arises because a Worker and/or Dependent reaches a lifetime cap on benefits, the 60-day period shall run from the date his/her first claim is denied by application of that lifetime cap.) The completed application must include a Certificate of Creditable Coverage or other documentation approved by the Plan Administrator to verify the Worker's and/or Dependent's previous health plan or health insurance coverage.

A Worker enrolling himself/herself and, if applicable, any Dependent under this Plan pursuant to this subsection 1 must select a Coverage Option in the enrollment application.

If a Covered Worker is enrolling a Dependent under this Plan pursuant to this subsection 1, the Covered Worker must select a Coverage Option in the enrollment application. *In this case, coverage for the Dependent under the Basic Plan Option may not be elected under this subsection 1, unless the Covered Worker also elects coverage under the Basic Plan Option in lieu of coverage under this Plan*.

b) ***Effective Date.*** If a Worker timely enrolls for Plan coverage under this subsection 1, Plan coverage will be effective on the date the Worker and/or Dependent lost coverage under the other health plan, as evidenced by a notice provided by such other health plan. The foregoing notwithstanding, a Worker may elect to have coverage become effective as of a later date, provided the effective date elected by the Worker is no later than 60 days after the date the Plan Administrator receives the timely enrollment application (described in paragraph a) above).

2. ***New Dependent Enrollment***

If a Worker gains a new Dependent, the Worker may enroll for health benefit coverage under the WELS VEBA Group Health Care Plan (whether under this Plan or the Basic Plan Option) for (a) the Worker, or (b) the Worker (i.e., if not already a Member) and

his/her Dependents.

a) ***Procedure*****.** To enroll, the Worker must submit an appropriately completed enrollment application to the Plan Administrator as follows:

- A Worker with a new Spouse must submit a completed application to the Plan Administrator within 60 days of the marriage date.

- A Worker with a newborn Dependent Child must submit a completed application to the Plan Administrator as follows:

    - If the Worker is not a Covered Worker on the date of the newborn Dependent Child's birth, the Worker must submit the completed application to the Plan Administrator within 60 days of the child's birth;

    - If the Worker is a Covered Worker on the date of the newborn Dependent Child's birth, the Worker must submit the completed application to the Plan Administrator:

        - Within 60 days of the child's birth to enroll the newborn Dependent Child and any other Dependent; and

        - Within two years of the child's birth to enroll only the newborn Dependent Child. (*Enrollment more than 60 days after the child's date of birth under this provision will be permitted only if the Worker has remained a Covered Worker*.)

- A Worker with a Dependent Child who is adopted by, or placed for adoption with, the Worker must submit a completed application to the Plan Administrator as follows:

    - If the Worker is not a Covered Worker on the child's adoption date or, if earlier, placement for adoption date, the Worker must submit the completed application to the Plan Administrator within 60 days of the child's adoption date or, if earlier, placement for adoption date;

    - If the Worker is a Covered Worker on the child's adoption date or, if earlier, placement for adoption date, the Worker must submit the completed application to the Plan Administrator:

        - Within 60 days of the child's adoption date or, if earlier, placement for adoption date for the enrollment of any Dependent other than the such child; and

        - Within two years of the child's adoption date or, if earlier, placement for adoption date for the enrollment of the Dependent Child adopted or placed for adoption. (*Enrollment more than 60 days after the adoption date or placement for adoption date, as applicable, under this provision will be permitted only if the Worker has remained a Covered Worker*.)

A Worker enrolling himself/herself and, if applicable, any Dependent under this Plan pursuant to this subsection 2 must select a Coverage Option in the enrollment

application.

If a Covered Worker is enrolling a Dependent under this Plan pursuant to this subsection 2, the Covered Worker must select a Coverage Option in the enrollment application. *In this case, coverage for the Dependent under the Basic Plan Option may not be elected under this subsection 2, unless the Covered Worker also elects coverage under the Basic Plan Option in lieu of coverage under this Plan. If the Covered Worker is enrolling a Dependent Child more than 60 days after the child's date of birth, adoption, or placement for adoption (as applicable), in accordance with this subsection 2, the Covered Worker may modify his/her Coverage Option in the enrollment application as necessary to cover that Dependent Child but may not elect coverage under the Basic Plan Option.*

A Worker enrolling himself/herself and, if applicable, any Dependent under this Plan pursuant to this subsection 2 must submit the completed enrollment application to the Plan Administrator through the WELS Benefits Service Center, as described under Section A "Initial Enrollment Period" above, within the applicable timeframe listed in this subsection 2.

b) ***Effective Date*****.** If a Worker timely enrolls for Plan coverage under this subsection 2, coverage will be effective as follows:

(i) If enrollment is based upon the Worker's marriage to a new Spouse, coverage will be effective on the marriage date.

(ii) If enrollment is based upon the birth of the Worker's Dependent Child, coverage will generally be effective on the date of birth. If the newborn Dependent Child of a Covered Worker is *timely* enrolled (as described in paragraph a) above) more than 120 days after the date of birth, however, Plan coverage for that Dependent Child will be effective on the first day of the first calendar month that begins after the date the Plan Administrator receives the appropriately completed enrollment application.

(iii) If enrollment is based upon a Dependent Child's adoption by, or placement for adoption with, the Worker, coverage will generally be effective on the earlier of the adoption date or the adoption placement date. If the Dependent Child adopted by, or placed for adoption with, the Covered Worker is *timely* enrolled (as described in paragraph a) above) more than 120 days after the earlier of the adoption date or the adoption placement date, however, Plan coverage for that Dependent Child will be effective on the first day of the first calendar month that begins after the date the Plan Administrator receives the appropriately completed enrollment application.

If special enrollment is based upon the Worker's marriage to a new Spouse and enrollment is *timely* (in accordance with paragraph a) above),the Worker may request a later effective date for Plan coverage provided the effective date requested is no later than 60 days after the marriage date. If special enrollment is based upon the birth, adoption or placement for adoption of the Worker's Dependent Child, enrollment is *timely* (in accordance with paragraph a) above), and enrollment occurs within 120 days after the date of birth, adoption or placement for adoption, then the Worker may request a later effective date for Plan coverage provided the effective date requested is no later than 60 days after the date of birth, adoption or placement for adoption.

3. ***Open Enrollment / Coverage Option Election Period***

If the Plan has an open enrollment period, then, during the open enrollment period:

- A Covered Worker may enroll his/her Dependents for coverage under the Plan; or

- An eligible Worker may enroll (a) the Worker, or (b) the Worker and his/her Dependents, for coverage under the WELS VEBA Group Health Care Plan (whether under this Plan or the Basic Plan Option); or

- A Covered Worker under the Plan may elect to change the Coverage Option applicable to the Covered Worker and, if applicable, his/her covered Dependents or change to the Basic Plan Option (which is described in a separate document).

  a) ***Procedure*****.** To make any of these enrollment or coverage changes, the Worker must submit an appropriately completed enrollment application to the Plan Administrator through the WELS Benefits Service Center, as described under Section A "Initial Enrollment Period" above, during the open enrollment period.

  b) ***Effective Date*****.** If a Worker timely enrolls for Plan coverage or modifies his/her Coverage Option under this Plan during an open enrollment period under this subsection 3, the effective date for Plan coverage (i.e., in the case of enrollment) or the new Coverage Option will be January 1 following the enrollment/election period.

Note: The Plan Administrator will determine whether the Plan will conduct an open enrollment. The Plan Administrator reserves the right to conduct, restrict or discontinue open enrollments. The Plan Administrator will notify Members and Sponsoring Organizations in advance of an open enrollment.

4. ***Employment Transfer***

An eligible Worker who is not a Covered Worker may enroll (a) the Worker, or (b) the Worker and his/her Dependents, for coverage under the Plan if the Worker accepts a new call or position with a new Sponsoring Organization.

If the Covered Worker accepts a new call or position with a new Sponsoring Organization, the Covered Worker may change his/her Plan Option and/or Coverage Option and/or enroll his/her Dependents, or the Covered Worker may change to the Basic Plan Option (which is described in a separate document).

a) ***Procedure*****.** To enroll for Plan health benefit coverage or to make a Coverage Option change, an eligible Worker or Covered Worker must submit an appropriately completed enrollment application to the Plan Administrator through the WELS Benefits Service Center, as described under Section A "Initial Enrollment Period" above, within 60 days of the effective date of the new call or position.

b) ***Effective Date*****.** If, in accordance with the procedure described in a) above, a Covered Worker changes his/her Coverage Option and/or enrolls his/her Dependent(s) in conjunction with the Covered Worker's acceptance of a new call or position with a new Sponsoring Organization, the effective date of that new Coverage Option and/or Dependent enrollment shall be the later of:

- the effective date of the new call or position; or

- the date requested by the Covered Worker in the timely completed and submitted enrollment application, provided the requested date is no later than 60 days after the effective date of the new call or position.

If, in accordance with the procedure described in a) above, an eligible Worker who is not a Covered Worker enrolls for coverage for the Worker or the Worker and his/her Dependent(s) in conjunction with the Worker's acceptance of a new call or position with a new Sponsoring Organization, that coverage will be effective as of the latest of:

- the effective date of the new call or position with the new Sponsoring Organization;

- the date the Plan Administrator receives the Worker's timely completed and submitted enrollment application; or

- the date requested by the Worker in the timely completed and submitted enrollment application, provided the requested date is no later than 60 days after the effective date of the new call or position.

5. ***Qualified Medical Child Support Orders***

Notwithstanding any other provision of the Plan, the Plan will provide benefits in accordance with any Qualified Medical Child Support Order (as defined in section 609(a)(2) of the Employee Retirement Income Security Act of 1974). The Plan Administrator has developed written guidelines and will determine whether an order is a Qualified Medical Child Support Order. A Member may request a copy of the procedures, without charge, from the Benefit Plans Office.

6. Change in Medicaid or Children's Health Insurance Program ("CHIP") status

An eligible Worker may enroll in health benefit coverage under the WELS VEBA Group Health Care Plan for (a) the Worker, or (b) the Worker (i.e., if not already a Member) and his/her Dependents if:

- The Worker or Dependent loses Medicaid or CHIP coverage because of a loss of eligibility; or

- The Worker or Dependent becomes eligible for a Medicaid or CHIP premium assistance subsidy.

a) **Procedure**. To enroll based upon a loss of Medicaid or CHIP coverage due to a loss of eligibility, the Worker must submit an appropriately completed enrollment application to the Plan Administrator through the WELS Benefits Service Center, as described under Section A "Initial Enrollment Period" above, within 60 days after such loss of coverage of the Worker and/or Dependent occurs. To enroll due to the Worker and/or Dependent becoming eligible for a Medicaid or CHIP premium assistance subsidy, the Worker must submit an appropriately completed enrollment application to the Plan Administrator

through the WELS Benefits Service Center, as described under Section A "Initial Enrollment Period" above, within 60 days after the eligibility determination.

A Worker enrolling himself/herself and, if applicable, any Dependent under this Plan pursuant to this subsection 6 must select a Plan Option and Coverage Option in the enrollment application.

If a Covered Worker is enrolling a Dependent under this Plan pursuant to this subsection 6, the Covered Worker must select a Coverage Option in the enrollment application. *In this case, coverage for the Dependent under the Basic Plan Option may not be elected under this subsection 6, unless the Covered Worker also elects coverage under the Basic Plan Option in lieu of coverage under this Plan.*

b) **Effective Date**. If a Worker timely enrolls for Plan coverage under this subsection 6 based upon a loss of Medicaid or CHIP coverage because of a loss of eligibility, Plan coverage will be effective on the date the Worker or Dependent loses Medicaid or CHIP coverage because of such loss of eligibility. In the timely completed and submitted enrollment application, a Worker may elect to have coverage become effective as of a later date, provided the effective date elected by the Worker is no later than 60 days after the date the Worker or Dependent loses Medicaid or CHIP coverage because of such loss of eligibility.

If a Worker timely enrolls for Plan coverage under this subsection 6 based upon becoming eligible for a Medicaid or CHIP premium assistance subsidy, Plan coverage will be effective on the date of the determination that Worker or Dependent is eligible for such Medicaid or CHIP premium assistance subsidy. In the timely completed and submitted enrollment application, a Worker may elect to have coverage become effective as of a later date, provided the effective date elected by the Worker is no later than 60 days after the date of the determination that Worker or Dependent is eligible for such Medicaid or CHIP premium assistance subsidy.

LEAVE OF ABSENCE PROVISIONS

Family and Medical Leave Act of 1993

If an Employer grants an FMLA leave, the Covered Worker and the Covered Worker's covered Dependents shall continue under the Plan as if the Covered Worker were actively employed. On the date that the Covered Worker notifies the Employer that the Covered Worker will not return or, if later, the date that the statutory leave period expires, the Covered Worker and the Covered Worker's covered Dependents may enroll for COBRA Coverage, Surviving Spouse Coverage, Retired Worker Coverage, or Disabled Worker Coverage if otherwise eligible.

Other Leaves of Absence

If an Employer grants a leave of absence that does not qualify as an FMLA leave, the Covered Worker and the Covered Worker's covered Dependents may remain in the Plan by enrolling in COBRA Coverage, Surviving Spouse Coverage, Retired Worker Coverage, or Disabled Worker Coverage if otherwise eligible.

CONTINUATION OF COVERAGE

A. Surviving Spouse Coverage

In lieu of COBRA Coverage, a surviving Spouse of a deceased Covered Worker ("Surviving Spouse") covered under the Plan at the time of the Covered Worker's death may continue the level of Plan coverage (i.e., the Plan Option) in effect at the time of the Covered Worker's death on a self-pay basis ("Surviving Spouse Coverage"), as described below.

(1) Enrollment. To enroll for Surviving Spouse Coverage, the Surviving Spouse must submit an appropriately completed enrollment application to the Plan Administrator through the WELS Benefits Service Center website (www.wels.bswift.com) within 60 days following the end of the calendar month in which the Covered Worker's death occurred. (Note: A Surviving Spouse cannot enroll for Surviving Spouse Coverage under the Plan's Special Enrollment Provisions.) A Surviving Spouse may also enroll by contacting the WELS Benefits Service Center by telephone at 1-800-487-8322, or by email at wels@bswift.com. For more information regarding enrollment, contact the WELS Benefits Service Center at 1-800-487-8322.

(2) Coverage Option. The Surviving Spouse may elect individual coverage or individual plus child(ren) coverage (i.e., for any Dependent Child who is a Dependent and was covered by the Plan at the time of the Covered Worker's death). The Plan will not cover new Family Members acquired by the Surviving Spouse while covered under Surviving Spouse Coverage (i.e., based upon his/her Surviving Spouse Coverage).

(3) Required Contributions. To obtain and retain Surviving Spouse Coverage under this Section A, the Surviving Spouse must timely pay required contributions to the Plan Administrator. The Plan Administrator will determine the amount of required contributions due for Surviving Spouse Coverage.

(4) Termination of Surviving Spouse Coverage for Surviving Spouse. Surviving Spouse Coverage for a Surviving Spouse under this Section A will terminate as of the earliest of the following dates:

(a) The date the Synod ceases to provide a group health Plan to any Worker.

(b) The last day of the coverage period immediately preceding the coverage period for which the Plan Administrator does not timely receive required contributions with respect to such coverage.

(c) The date the Surviving Spouse, after electing Surviving Spouse Coverage, becomes covered under another group health plan (including, without limitation, this Plan) or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare).

(d) The effective date of any Plan amendment that results in the termination of the Surviving Spouse's Surviving Spouse Coverage, provided termination under this paragraph (d) shall not occur before the last day of the COBRA Coverage period that would have applied to the Surviving Spouse as a result of the death of the Covered Worker.

(e) The date the Surviving Spouse attains age 65.

(5) Termination of Surviving Spouse Coverage for Dependent Child. Except as provided in subsection (6) below, termination of the Surviving Spouse Coverage for a Surviving Spouse under subsection (4) above would have the effect of terminating related Dependent Child coverage under this Section A (provided the effective date of such termination shall not occur before the last day of the COBRA Coverage period that would have applied to that child as a result of the death of the Covered Worker). In addition, coverage of a Dependent Child under this Section A will terminate as of the earliest of the following dates:

(a) The date the Dependent Child, after coverage for the Dependent Child under this Section A is elected, becomes covered under another group health plan (including, without limitation, this Plan) or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare).

(b) The last day of the month in which the Dependent Child ceases to qualify as a Dependent of the Surviving Spouse, provided termination under this paragraph (b) shall not occur before the last day of the COBRA Coverage period that would have applied to that child as a result of the death of the Covered Worker.

(c) The effective date of any Plan amendment that results in the termination of the Dependent Child's Plan coverage, provided termination under this paragraph (c) shall not occur before the last day of the COBRA Coverage period that would have applied to that child as a result of the death of the Covered Worker.

(d) The last day of the coverage period immediately preceding the coverage period for which the Plan Administrator does not timely receive required contributions with respect to such coverage.

(6) Medicare Coverage/Age 65. If the Surviving Spouse's Surviving Spouse Coverage terminates due to the Surviving Spouse becoming covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare) or attaining age 65, a covered Dependent Child of the Surviving Spouse may continue coverage under this Plan until the earliest of the following dates:

(a) The date the Dependent Child, after Surviving Spouse Coverage for the Dependent is elected, becomes covered under another group health plan (including, without limitation, this Plan) or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare).

(b) The last day of the month in which the Dependent Child ceases to qualify as a Dependent of the Surviving Spouse, provided termination under this paragraph (b) shall not occur before the last day of the COBRA Coverage period that would have applied to that child as a result of the death of the Covered Worker.

(c) The last day of the coverage period immediately preceding the coverage period for which the Plan Administrator does not timely receive required contributions with respect to such coverage.

(d) The effective date of any Plan amendment that results in the termination of the Dependent Child's Plan coverage, provided termination under this paragraph (d) shall not occur before the last day of the COBRA Coverage period that would have

applied to that child as a result of the death of the Covered Worker.

(e) The date the Synod ceases to provide a group health plan to any Worker.

(7) Time of Coverage Termination. If coverage terminates as of a specified day under this Section A, that coverage will terminate at 11:59 PM on such day.

B. Retired Worker Coverage

In lieu of COBRA Coverage, a Covered Worker who ceases to be a Worker after attaining age 55 and with three years of continuous membership in the Plan (i.e., ending on the date he/she ceased to be a Worker) may continue the level of coverage (i.e., Plan Option) in effect under the Plan as a Retired Worker ("Retired Worker Coverage").

(1) Enrollment. To enroll for Retired Worker Coverage, an eligible Covered Worker must submit a completed enrollment application to the Plan Administrator through the WELS Benefits Service Center website (www.wels.bswift.com) within 60 days following the date he/she ceased to be a Worker. (Note: A retiree or other former Worker cannot enroll for Retired Worker Coverage under the Plan's Special Enrollment Provisions.) A Retired Worker may also enroll by contacting the WELS Benefits Service Center by telephone at 1-800-487-8322, or by email at wels@bswift.com. For more information regarding enrollment, contact the WELS Benefits Service Center at 1-800-487-8322.

(2) Coverage Option. When enrolling for Retired Worker Coverage, an eligible Covered Worker may elect to continue Plan coverage for any Dependent who is covered under the Plan at the time the Retired Worker ceases to be a Worker by enrolling the Dependent under the Covered Worker's Retired Worker Coverage and electing the appropriate Coverage Option. The Plan will not cover new Dependents acquired by the Retired Worker while covered under Retired Worker Coverage (i.e., based upon his/her Retired Worker Coverage), except as provided under the Special Enrollment Provisions for New Dependents discussed above.

(3) Required Contributions. To obtain and retain Retired Worker Coverage under this Section B, the Retired Worker must timely pay required contributions to the Plan Administrator. The Plan Administrator will determine the amount of required contributions due for Retired Worker Coverage.

(4) Missionaries. For purposes of determining whether a Covered Worker has three years of continuous membership in the Plan, a period of coverage under the Aetna Global Benefit plan maintained by the Synod (or any successor to that plan) for foreign missionaries (the "Missionary Plan") shall be treated as coverage under this Plan. In addition, if at the time a Worker ceases to be a Worker, the Worker (a) is covered under the Missionary Plan, (b) has attained at least age 55, and (c) has three years of continuous membership under this Plan and/or the Missionary Plan (i.e., ending on the date he/she ceased to be a Worker), then the Worker may:

- Enroll for Retired Worker Coverage in this Plan (and select a Plan Option) or the Basic Plan Option (the enrollment rules for which are described in a separate document); and,

- Enroll his/her dependents for coverage under this Plan (selecting an appropriate Coverage Option) if the dependents qualify as "Dependents" under this Plan and were

covered under the Missionary Plan when the Worker ceased to be a Worker.

(5) Termination of Retired Worker Coverage for the Retired Worker. Retired Worker Coverage for a Retired Worker under this Section B will terminate as of the earliest of the following dates:

(a) The date the Synod ceases to provide a group health plan to any Worker.

(b) The last day of the coverage period immediately preceding the coverage period for which the Plan Administrator does not timely receive required contributions with respect to such coverage.

(c) The date the Retired Worker, after electing Retired Worker coverage under this Section B, becomes covered under another group health plan or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare).

(d) The effective date of any Plan amendment that results in the termination of the Retired Worker's Retired Worker Coverage, provided termination under this paragraph (d) shall not occur before the last day of the COBRA Coverage period that would have applied to the Retired Worker as a result of his/her ceasing to be a Worker.

(e) The date the Retired Worker attains age 65. The foregoing notwithstanding, the attainment of age 65 will not terminate Retired Worker Coverage if the Retired Worker retired as a foreign missionary and the Retired Worker's principal residence (as determined by the Plan Administrator) is outside the United States.

(6) Termination of Retired Worker Coverage for Dependent. Except as provided in subsection (7) below, termination of Retired Worker Coverage for a Retired Worker under subsection (5) above would have the effect of terminating related Dependent coverage under this Section B (provided the effective date of such termination shall not occur before the last day of the COBRA Coverage period that would have applied to that Dependent had COBRA Coverage been elected for that Dependent at the time the Retired Worker ceased to be a Worker). In addition, coverage of a Dependent under this Section B will terminate as of the earliest of the following dates:

(a) The date the Dependent, after coverage for the Dependent under this Section B is elected, becomes covered under another group health plan (including, without limitation, this Plan) or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare).

(b) The last day of the month in which the Dependent ceases to qualify as a Dependent of the Retired Worker, provided, in the case of a Dependent Child, termination under this paragraph (b) shall not occur before the last day of the COBRA Coverage period that would have applied to that child had COBRA Coverage been elected for that child at the time the Retired Worker ceased to be a Worker.

(c) The effective date of any Plan amendment that results in the termination of the Dependent's Plan coverage, provided termination under this paragraph (c) shall not occur before the last day of the COBRA Coverage period that would have applied to that Dependent had COBRA Coverage been elected for that Dependent at the

time the Retired Worker ceased to be a Worker.

(d) The last day of the coverage period immediately preceding the coverage period for which the Plan Administrator does not timely receive required contributions with respect to such coverage.

(7) Medicare Coverage/Age 65. If the Retired Worker's Retired Worker Coverage terminates due to the Retired Worker becoming covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare) or attaining age 65, a covered Dependent of the Retired Worker may continue coverage under this Plan until the earliest of the following dates:

(a) The date the Dependent, after Retired Worker Coverage for the Dependent is elected, becomes covered under another group health plan (including, without limitation, this Plan) or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare).

(b) The last day of the month in which the Dependent ceases to qualify as a Dependent of the Retired Worker, provided, in the case of a Dependent Child, termination under this paragraph (b) shall not occur before the last day of the COBRA Coverage period that would have applied to that child had COBRA Coverage been elected for that child at the time the Retired Worker ceased to be a Worker.

(c) The last day of the coverage period immediately preceding the coverage period for which the Plan Administrator does not timely receive required contributions with respect to such coverage.

(d) The effective date of any Plan amendment that results in the termination of the Dependent's Plan coverage, provided termination under this paragraph (d) shall not occur before the last day of the COBRA Coverage period that would have applied to that Dependent had COBRA Coverage been elected for that Dependent at the time the Retired Worker ceased to be a Worker.

(e) The date the Synod ceases to provide a group health plan to any Worker.

(8) Time of Coverage Termination. If coverage terminates as of a specified day under this Section A, that coverage will terminate at 11:59 PM on such day.

C. Disabled Worker Coverage

In lieu of COBRA Coverage, a Covered Worker who terminates employment due to becoming Totally Disabled may continue the level of coverage (i.e., Plan Option) in effect under the Plan as a Disabled Worker ("Disabled Worker Coverage").

(1) Enrollment. To enroll for Disabled Worker Coverage, a Covered Worker must submit a completed enrollment application to the Plan Administrator through the WELS Benefits Service Center website (www.wels.bswift.com) within 60 days following the date of his/her termination of employment due to becoming Totally Disabled. (Note: A former Worker (whether or not disabled) cannot enroll for Disabled Worker Coverage under the Plan's Special Enrollment Provisions.) A Disabled Worker may also enroll by contacting the WELS Benefits Service Center by telephone at 1-800-487-8322, or by email at wels@bswift.com. For more information regarding enrollment, contact the WELS

Benefits Service Center at 1-800-487-8322.

(2) Coverage Option. When enrolling for Disabled Worker Coverage, an eligible Covered Worker may elect to continue Plan coverage for any Dependent who is covered under the Plan at the time the Covered Worker terminates employment due to becoming Totally Disabled by enrolling the Dependent under the Covered Worker's Disabled Worker Coverage and electing the appropriate Coverage Option. The Plan will not cover new Dependents acquired by the Covered Worker while covered under Disabled Worker Coverage (i.e., based upon his/her Disabled Worker Coverage), except as provided under the Special Enrollment Provisions for New Dependents discussed above.

(3) Required Contributions. To obtain and retain Disabled Worker Coverage under this Section C, the Disabled Worker must timely pay required contributions to the Plan Administrator. The Plan Administrator will determine the amount of required contributions due for Disabled Worker Coverage.

(4) Termination of Disabled Worker Coverage for the Disabled Worker. Disabled Worker Coverage for a Disabled Worker under this Section C will terminate as of the earliest of the following dates:

(a) The date the Synod ceases to provide a group health plan to any Worker.

(b) The last day of the coverage period immediately preceding the coverage period for which the Plan Administrator does not timely receive required contributions with respect to such coverage.

(c) The date the Disabled Worker, after electing Disabled Worker coverage under this Section C, becomes covered under another group health plan or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare).

(d) The effective date of any Plan amendment that results in the termination of the Disabled Worker's Disabled Worker Coverage, provided termination under this paragraph (d) shall not occur before the last day of the COBRA Coverage period that would have applied to the Disabled Worker's termination of employment due to becoming Totally Disabled.

(e) The first day of the month that begins more than 30 days after the date a final determination is made that the Disabled Worker ceases to be Totally Disabled.

(f) The date the Disabled Worker attains age 65.

(5) Termination of Disabled Worker Coverage for Dependent. Except as provided in subsection (6) below, termination of Disabled Worker Coverage for a Disabled Worker under subsection (4) above would have the effect of terminating related Dependent coverage under this Section C (provided the effective date of such termination shall not occur before the last day of the COBRA Coverage period that would have applied to that Dependent had COBRA Coverage been elected for that Dependent at the time of the Disabled Worker's termination of employment due to becoming Totally Disabled.). In addition, coverage of a Dependent under this Section C will terminate as of the earliest of the following dates:

(a) The date the Dependent, after coverage for the Dependent under this Section C is elected, becomes covered under another group health plan (including, without limitation, this Plan) or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare).

(b) The last day of the month in which the Dependent ceases to qualify as a Dependent of the Disabled Worker, provided, in the case of a Dependent Child, termination under this paragraph (b) shall not occur before the last day of the COBRA Coverage period that would have applied to that child had COBRA Coverage been elected for that child at the time of the Disabled Worker's termination of employment due to becoming Totally Disabled.

(c) The effective date of any Plan amendment that results in the termination of the Dependent's Plan coverage, provided termination under this paragraph (c) shall not occur before the last day of the COBRA Coverage period that would have applied to that Dependent had COBRA Coverage been elected for that Dependent at the time of the Disabled Worker's termination of employment due to becoming Totally Disabled.

(d) The last day of the coverage period immediately preceding the coverage period for which the Plan Administrator does not timely receive required contributions with respect to such coverage.

(6) **Medicare Coverage/Age 65.** If the Disabled Worker's Disabled Worker Coverage terminates due to the Disabled Worker becoming covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare) or attaining age 65, a covered Dependent of the Retired Worker may continue coverage under this Plan until the earliest of the following dates:

(a) The date the Dependent, after Disabled Worker Coverage for the Dependent is elected, becomes covered under another group health plan (including, without limitation, this Plan) or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare).

(b) The last day of the month in which the Dependent ceases to qualify as a Dependent of the Disabled Worker, provided, in the case of a Dependent Child, termination under this paragraph (b) shall not occur before the last day of the COBRA Coverage period that would have applied to that child had COBRA Coverage been elected for that child at the time of the Disabled Worker's termination of employment due to becoming Totally Disabled.

(c) The effective date of any Plan amendment that results in the termination of the Dependent's Plan coverage, provided termination under this paragraph (c) shall not occur before the last day of the COBRA Coverage period that would have applied to that Dependent had COBRA Coverage been elected for that Dependent at the time of the Disabled Worker's termination of employment due to becoming Totally Disabled.

(d) The last day of the coverage period immediately preceding the coverage period for which the Plan Administrator does not timely receive required contributions with respect to such coverage.

(e) The date the Synod ceases to provide a group health plan to any Worker.

(7) Time of Coverage Termination. If coverage terminates as of a specified day under this Section C, that coverage will terminate at 11:59 PM on such day.

D. COBRA Continuation Coverage

Each person who is a Qualified Beneficiary shall have the right to elect continued coverage under this Plan upon the occurrence of a Qualifying Event that would otherwise result in such person losing health coverage under the Plan. The extended coverage under this Section C is known as "COBRA Coverage."

(1) Qualified Beneficiary. A "Qualified Beneficiary" is any person who, as of the day before a Qualifying Event, is:

(a) A Covered Worker;

(b) The Spouse of a Covered Worker and covered under the Plan; or

(c) The Dependent Child of a Covered Worker and covered under the Plan.

A Covered Worker can be a Qualified Beneficiary only if the Qualifying Event is described in subsection (2)(b). A retiree or other former Worker actively participating in the Plan by reason of a previous period of employment may be treated as a "Qualified Beneficiary" to the extent described in subsection (2).

An individual who fails to elect COBRA Coverage within the election period provided in subsection (5) shall not be considered a Qualified Beneficiary.

(2) Qualifying Event. Any of the following shall be considered a "Qualifying Event" if it would result in the loss of health benefit coverage under the Plan.

(a) Death of the Covered Worker.

(b) Termination of the Covered Worker's employment or a reduction of hours of employment below any minimum level of hours required for participation in this Plan. In the case of a Covered Worker who:

(i) does not return to covered employment at the end of an FMLA leave, the Qualifying Event of termination occurs on the earlier of the last day of the FMLA leave or the date the Covered Worker notifies his/her Employer of the intention not to return to active employment; or

(ii) is absent more than 31 days due to a period of duty with the Uniformed Services, the Qualifying Event occurs on the first day of such absence.

(c) Divorce or legal separation of the Covered Worker from the Covered Worker's Spouse.

(d) A Covered Worker becoming eligible to receive Medicare benefits under Title XVIII of the Social Security Act (Part A, Part B, or both).

(e) A Dependent Child of a Covered Worker ceasing to be a Dependent.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Sponsoring Organization, and that bankruptcy results in the loss of coverage of any Retired Worker covered under the Plan, the Retired Worker may be a Qualified Beneficiary with respect to the bankruptcy. The Retired Worker's Spouse, Surviving Spouse, and Dependent Children may also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

(3) Benefit Available Under COBRA Coverage. A Qualified Beneficiary who is eligible to elect to continue coverage under this Section C shall have the right to continue the level of coverage in effect on the day before the Qualifying Event. If that coverage changes for similarly situated Covered Worker (or, in the case of a Dependent, for similarly situated covered Dependents), then coverage will change for those on COBRA Coverage. In addition, if the health coverage options given to similarly situated Covered Workers (or, in the case of a Dependent, to similarly situated covered Dependents) under the WELS VEBA Group Health Care Plan health benefit coverage change, those options will be available to those on COBRA Coverage. Each Qualified Beneficiary who elects COBRA Coverage will have the same rights under the Plan as other Covered Workers and Dependents covered under the Plan, including Open Enrollment (if applicable) and Special Enrollment rights (discussed above).

(4) Notice Requirements

(a) Notice Upon Commencement of Coverage. When a Worker becomes a Covered Worker under this Plan, the Plan Administrator will inform the Covered Worker (and the Covered Worker's Spouse, if any) in writing of the rights to continued coverage under this Section C. (This document will satisfy this written notice requirement.)

(b) Notice of Qualifying Event. The Plan will offer COBRA Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

(i) The Covered Worker's Employer must give the Plan Administrator written notice of a Qualifying Event described in subsection 2(a), (b), or (d) (or a Qualifying Event resulting from the Employer's filing of a bankruptcy petition) within thirty (30) days of the occurrence thereof.

(ii) Within fourteen (14) days of receipt of the Employer's notice (described in subparagraph (i)), the Plan Administrator shall furnish each Qualified Beneficiary with written notification of the termination of regular coverage under the Plan, as well as a recital of the rights of any such Qualified Beneficiary to elect COBRA Coverage as required by Internal Revenue Code section 4980B and section 601 of the Employee Retirement Income Security Act of 1974, in accordance with the terms of this Plan.

(iii) In the case of a Qualifying Event described in subsection 2(c) or (e), a Covered Worker or Qualified Beneficiary who is a Spouse or Dependent of such Covered Worker must notify the Plan Administrator in writing within sixty (60) days of the occurrence thereof. The Plan Administrator shall give

written notification of COBRA Coverage rights to any affected Qualified Beneficiary within fourteen (14) days of its receipt of the notice described in this subparagraph (iii).

(c) **Notice of Address Changes**. To protect your family's rights, you, as a Covered Worker or a covered Spouse of a Covered Worker, should keep the Plan Administrator informed of any changes in the addresses of your family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a Spouse of a Covered Worker is treated as notification to all other Qualified Beneficiaries residing with that Spouse at the time notification is made.

(5) Election Period. A Qualified Beneficiary entitled to COBRA Coverage shall have sixty (60) days from the later of the date coverage would otherwise end or date of the notice required by subsection (4) is delivered in which to return a signed election to the Plan Administrator indicating the choice to continue benefits under this Plan. Each Qualified Beneficiary will have an independent right to elect COBRA Coverage. Covered Workers may make COBRA Coverage elections on behalf of their Spouses, and parents may make COBRA Coverage elections on behalf of their children.

If a Qualified Beneficiary initially elects to waive COBRA Coverage, the Qualified Beneficiary may revoke that waiver election at any time during the 60-day election period. The Plan, however, will only provide COBRA Coverage beginning with the date of the revocation of the waiver election and not retroactively. This will result in a lapse of continuous coverage under the Plan.

If the Qualified Beneficiary is totally incapacitated and is not legally competent to make a COBRA Coverage election, the 60-day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

(6) Duration of COBRA Coverage. Unless terminated earlier pursuant to subsection (8), COBRA Coverage will be available for the following periods, as applicable.

(a) **Termination of Employment/Reduction in Hours—18-Month Rule**. COBRA Coverage shall extend for a period of eighteen (18) months after the date that regular coverage ends due to the Covered Worker's termination of employment or reduction of hours of employment to a level that disqualifies him/her from participation in the Plan.

(i) **Extension to 29 Months—Disability.** This eighteen (18) month period is extended to twenty-nine (29) months if the Social Security Administration ("SSA") determines within the eighteen (18) month period that a Qualified Beneficiary was disabled some time before the 60th day of COBRA Coverage. To secure the extended coverage after a determination of disability, the Qualified Beneficiary must notify the Plan Administrator of SSA's finding within sixty (60) days of its issue.

If a Qualified Beneficiary obtains 29 months of COBRA Coverage under this subparagraph (i) because a Qualified Beneficiary was disabled, the Qualified

Beneficiary must notify the Plan Administrator of any determination by the SSA that the previously disabled Qualified Beneficiary is no longer disabled. Notification to the Plan Administrator must be made within 30 days of the date such determination is made.

(ii) **Second Qualifying Event.** If, during the eighteen (18) month period (or twenty-nine (29) month period if subparagraph (i) applies), a subsequent Qualifying Event occurs (i.e., that would have resulted in a loss of coverage had the initial Qualifying Event not occurred), each Qualified Beneficiary (other than the Covered Worker) having COBRA Coverage shall be entitled to elect to continue coverage under the Plan for up to thirty-six (36) months following the date coverage was originally lost due to termination of employment or reduction of hours. Notice of the second Qualifying Event must be given to the Plan Administrator for this extension to apply. In no event shall COBRA Coverage extend more than thirty-six (36) months beyond the date regular coverage would otherwise have ended as a result of the original Qualifying Event.

(iii) **Entitlement to Medicare.** If the Covered Worker became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event of his/her termination of employment or reduction of hours, the Covered Worker's Spouse and each covered Dependent Child shall be eligible to elect to continue coverage until the date that is thirty-six (36) months from the date the Covered Worker first became so entitled. For purposes of determining COBRA Coverage rights "entitlement" means actual enrollment for Medicare benefits.

(b) Other Qualifying Events—36-Month Rule. Thirty-six (36) months of COBRA Coverage shall be available to:

(i) A Covered Worker's Spouse or Dependent Child who loses coverage under this Plan by virtue of the Spouse's divorce or legal separation from the Covered Worker;

(ii) A Dependent Child of the Covered Worker who loses coverage by ceasing to be a Dependent;

(iii) Any Spouse or Dependent Child who loses coverage where the Qualifying Event is the Worker's death;

(iv) Any Spouse or Dependent Child where the Covered Worker's entitlement to Medicare benefits results in loss of coverage under this Plan.

(7) Birth or Adoption of a Child. If through birth, adoption or placement for adoption a former Covered Worker acquires a new Dependent Child during a period of COBRA Coverage, then such child shall be treated as a Qualified Beneficiary eligible to elect COBRA Coverage for the remainder of the COBRA Coverage period to which that child would have been entitled had the child been a Dependent Child at the time of the Qualifying Event.

(8) Automatic Termination of COBRA Coverage. Notwithstanding any other provision of this Section C to the contrary, COBRA Coverage shall automatically cease if any of the

following events occurs:

(a) The Synod ceases to offer a group health plan to any Worker.

(b) The required monthly contribution, as defined in subsection (9), for COBRA Coverage is not timely paid within the period prescribed under subsection (9).

(c) After electing COBRA Coverage, an electing Qualified Beneficiary becomes covered under another group health plan or covered under a medical benefit program established pursuant to title XVIII of the Social Security Act (Medicare). If the Qualified Beneficiary has a condition that is not covered under the other group health plan because the other group health plan contains a pre-existing condition limitation, then the Qualified Beneficiary may continue COBRA Coverage under the Plan for the period of time that he/she is denied coverage under the other group health Plan for the pre-existing condition, but no longer than the COBRA Coverage period for which the Qualified Beneficiary is eligible. (COBRA Coverage under the Plan will not be permitted if the other group health plan contains a pre-existing condition exclusion or limitation, which does not apply to the Qualified Beneficiary by reason of the other group health plan's portability, access, and renewability provision restricting the application of the pre-existing condition limitation.)

(d) For a Qualified Beneficiary who has extended COBRA Coverage due to SSA disability status of Qualified Beneficiary under subsection (6)(a)(i), the date on which the Qualified Beneficiary is no longer considered to be disabled by SSA (i.e., provided such date is not before the end of the maximum COBRA Coverage period that would have applied without regard to the disability extension).

(9) Required Monthly Contribution. To obtain COBRA Coverage, a Qualified Beneficiary must pay the required monthly contribution to the Plan Administrator. The amount of the required monthly contribution shall be determined by the Plan Administrator in accordance with Internal Revenue Code section 4980B and will not exceed 102% of the applicable premium for the period in question. If the COBRA Coverage period is extended under subsection (6)(a)(i), the Plan Administrator may charge up to 150% of the applicable premium for the eleven (11) additional months of coverage provided as a result of the disability.

The required monthly contribution is due as of the first day of each calendar month during which COBRA Coverage is continued under this Section C. A required monthly contribution payment shall be considered timely if it is made within thirty (30) days after the date such payment is due.

The initial required monthly contribution for COBRA Coverage shall be considered timely if made by the later of (a) the date that is forty-five (45) days after the date the Qualified Beneficiary timely elects COBRA Coverage pursuant to subsection (5) or (b) the date that is thirty (30) days after the first day of the first calendar month of COBRA Coverage. If the initial required monthly contribution is timely, as described in the preceding sentence, but is paid more than thirty (30) days after the due date of a required monthly contribution for a month of COBRA Coverage, the initial required monthly contribution shall include the required monthly contribution for that month.

(10) Plan Contact Information. Any questions that you, as a Member, may have

concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Patient Protection and Affordable Care Act of 2010 (PPACA) and other laws affecting group health plans, you should contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in their area or visit the EBSA website at http://www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

WELS VEBA Commission
c/o Wisconsin Evangelical Lutheran Synod
Benefit Plans Office
N16W23377 Stone Ridge Dr
Waukesha, WI 53188
1-414-256-3299

COVERAGE OPTIONS OTHER THAN CONTINUING PLAN COVERAGE

A Member who would lose coverage under the Plan may have options for obtaining medical coverage other than continuing coverage under the Plan pursuant to the preceding provisions. He or she may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, he or she may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Additionally, he or she may qualify for a 30-day special enrollment period for another group health plan for which he or she is eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. Coverage options may also be available through Medicare or Medicaid. Some of these options may cost less than continuing coverage under the Plan. You can learn more about many of these options at www.healthcare.gov.

RE-ENROLLMENT AFTER MILITARY SERVICE

The Plan provides benefits in compliance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). A Worker who has served in the uniformed services should contact the WELS Benefit Plans Office for additional information regarding coverage and enrollment rights.

TERMINATION OF COVERAGE

A. Worker's Termination of Coverage

Unless a Covered Worker is eligible for and elects to continue Plan coverage under an applicable provision under "Continuation of Coverage" above, the Worker's Plan coverage will terminate as of the earliest of the following dates:

1. The last day of the month in which the Worker terminates employment. If the Worker has applied for long-term disability benefits under the long-term disability insurance plan sponsored by the Synod, coverage will not terminate under this subsection 1 before the end of the elimination period under that disability plan.
2. The date following the end of the designated leave period if the Covered Worker is on FMLA leave and does not return to employment immediately following the designated FMLA leave period (as provided under the section titled "Leave of Absence Provisions" above) (or, if earlier, the date the Worker notifies his/her Employer that he/she will not return to employment).
3. The date the Worker dies.
4. If the Plan Administrator does not timely receive required contributions with respect to the Worker's Plan coverage, the date specified by the Plan Administrator in a notice sent to the Worker's last known address.
5. The date the Worker withdraws from the Plan.
6. The date the Plan terminates.
7. The effective date of any Plan amendment that results in the termination of the Worker's Plan coverage.

B. Dependent's Termination of Coverage

Unless coverage for a covered Dependent is continued under an applicable provision under "Continuation Coverage" above, the covered Dependent's Plan coverage will terminate as of the earliest of the following dates:

1. The date Plan coverage of the Covered Worker through whom the Dependent obtains Plan coverage terminates.
2. The last day of the month in which he/she ceases to be a Dependent.
3. If the Plan Administrator does not timely receive required contributions with respect to the Dependent's Plan coverage, the date specified by the Plan Administrator in a notice sent to the Worker's last known address.
4. The date the Dependent dies.
5. The date the Plan terminates.
6. The effective date of any Plan amendment that has the effect of terminating the Dependent's Plan coverage.
7. The date the Covered Worker elects to discontinue coverage for the Dependent under the Plan, pursuant to rules and procedures established by the Plan Administrator.

If coverage terminates as of a specified day under Section A or Section B above, that coverage will terminate at 11:59 PM on such day.

HEALTH CARE MANAGEMENT

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

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

It is your responsibility to obtain Precertification. You should verify that the Provider obtains the required Precertification or obtain the required Precertification yourself. If you do not obtain any required Precertification, you are responsible for all charges for services Anthem, on behalf of the Plan Administrator, determines are not Medically Necessary. **If you do not obtain the required Precertification, a Retrospective Review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services Anthem, on behalf of the Plan Administrator, determines are not Medically Necessary.**

Types of Requests

***Precertification* –** A required review of a service, treatment or admission for a benefit coverage determination which, except as otherwise noted in this Summary Plan Description, must be obtained prior to the service, treatment or admission start date. For Inpatient admissions following Emergency Care, you, your authorized representative or your Physician must notify Anthem within 2 business days after the admission. For childbirth admissions, you, your authorized representative or your Physician must notify Anthem within 48 hours if your Physician determines that you will be admitted longer than forty-eight (48) hours for normal delivery or ninety-six (96) hours for C-section delivery due to a complication and/or the mother and baby will not be discharged at the same time.

***Predetermination* –** An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. Anthem, on behalf of the Plan Administrator, will review this Plan's provisions to determine if the service or treatment is a Covered Service. This includes a review of the Plan's exclusions as set forth in the Article of the Plan titled "Exclusions" as well as a review of the Medical Necessity and/or Experimental/Investigative nature of the service or treatment.

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

NOTICE: Precertification does NOT guarantee coverage for or the payment of the service or procedure reviewed.

You are responsible for obtaining Precertification for the following services:

The following list is not all inclusive and is subject to change; call the customer service telephone number on your Identification Card to confirm the most current list and requirements for this Plan.

Inpatient Admission:

- Inclusive of all Acute Inpatient, Acute Rehabilitation, Skilled Nursing Facility and Long Term Acute Care Hospital admissions
- Emergency admissions (requires Plan notification no later than 2 business days after admission)
- Precertification is not required for maternity admissions that result in childbirth, except for stays beyond forty-eight (48) hours for normal delivery and ninety-six (96) hours for C-section delivery (including newborn stays beyond the mother's stay). Requires Plan notification no later than 48 hours after Physician determines that extended stay is required.

Outpatient Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance (excludes 911 initiated emergency transport)
- Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Axial Lumbar Interbody Fusion
- Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
- Bariatric surgery and Other Treatments for Clinically Severe Obesity
- Bronchial Thermoplasty for Treatment of Asthma
- Canaloplasty and Viscocanalostomy
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- Corneal Collagen Cross-Linking
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diagnostic Testing
    - Cardiac Ion Channel Genetic Testing
    - Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
    - Gene Expression Profiling for Managing Breast Cancer Treatment
    - Genetic Testing for Breast and/or Ovarian Cancer Syndrome
    - Preimplantation Genetic Diagnosis Testing
    - Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders
    - Prostate Saturation Biopsy
- Diaphragmatic/Phrenic Nerve Stimulation Pacing Systems
- Durable Medical Equipment (DME)/Prosthetics (Precertification is required for any DME charges over $2,000.00. It is recommended to request Predetermination for all DME.):

    - Augmentative and Alternative Communication (AAC) Devices/Speech Generating Devices (SGD)
    - Dynamic Low-Load Prolonged-Duration Stretch Devices (LLPS)
    - Electrical Bone Growth Stimulation
    - Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
    - Implantable Infusion Pumps
    - Lower Limb Prosthesis and Microprocessor Controlled Lower Limb Prosthesis
    - Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
    - Prosthetics: Electronic or externally powered and select other prosthetics (myoelectric-UE)
    - Standing Frame
    - Ultrasound Bone Growth Stimulation
    - Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)
- Electric Tumor Treatment Field (TTF) for Treatment of Glioblastoma
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Immunoprophylaxis for Respiratory Syncytial Virus (RSV)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable or Wearable Cardioverter-Defibrillator (ICD)
- Implanted Devices for Spinal Stenosis
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Lumbar Discography
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Mechanical Embolectomy for Treatment of Acute Stroke
- Meniscal Allograft Transplantation of the Knee
- Occipital nerve stimulation
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- Perirectal Spacers for Use During Prostate Radiotherapy (Space Oar)

- Plastic/Reconstructive surgeries (It is recommended to request Predetermination for all Plastic/Reconstructive surgeries/treatments):
    - Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting, Hyperbaric Oxygen Therapy (Systemic/Topical)
    - Blepharoplasty
    - Breast Procedures; including Reconstructive Surgery, Implants and other Breast Procedures
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Insertion/Injection of Prosthetic Material Collagen Implants
    - Mandibular/Maxillary (Orthognathic) Surgery
    - Mastectomy for Gynecomastia
    - Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
    - Panniculectomy, Diastasis Recti Repair
    - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
    - Reduction Mammaplasty
    - Repair of Pectus Excavatum / Carinatum
    - Skin-Related Procedures
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing
- Radiation Therapy/Radiology Services
    - Intensity Modulated Radiation Therapy (IMRT)
    - MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
    - Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
    - Proton Beam Therapy
    - Radiofrequency Ablation to Treat Tumors Outside the Liver
    - Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
    - Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for treating Primary or Metastatic Liver Tumors
    - Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Malignant Lesions Outside the Liver—except CNS and Spinal Cord
    - Wireless Capsule Endoscopy for Gastrointestinal Imaging and Patency Capsule
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Specialty Prescription Drug Treatment
- Surgical and Ablative Treatments for Chronic Headaches
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Transanal Hemorrhoidal Dearterialization (THD)

- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation (Radiofrequency and Cryoablation)
- Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- Transcatheter Heart Valve Procedures
- Transcatheter Uterine Artery Embolization
- Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
- Transmyocardial/Periventricular Device Closure of Ventricular Septal Defects
- Treatment of Hyperhidrosis
- Treatment of Varicose Veins (Lower Extremities)
- Treatments for Urinary Incontinence
- Total Ankle Replacement
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Venous Angioplasty with or without Stent Placement/Venous Stenting

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admissions for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
    - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
    - Donor Leukocyte Infusion
- Axicabtagene ciloleucel (Yescarta) (CAR) T-cell Immunotherapy Treatment
- Tisagenlecleucel (Kymriah) (CAR) T-cell Immunotherapy Treatment
- Gene Therapy Treatment and Replacement
- Intrathecal Treatment of Spinal Muscular Atrophy (SMA)

Mental Health/Substance Abuse (MHSA)

- Acute Inpatient Admissions
- Intensive Outpatient treatment (IOP)
- Partial Hospitalization (PHP)
- Residential Treatment
- Transcranial Magnetic Stimulation (TMS)

Referrals

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

Requests for a referral to a Non-Network Provider for care that Anthem, on behalf of the Plan Administrator, determines is Medically Necessary may be approved as Authorized Services, based on Network adequacy.

NOTICE: Utilizing a Non-Network Provider may result in significant additional financial responsibility for you, because the Plan Administrator cannot prohibit a Non-Network Provider from billing you for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount for a Covered Service.

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

Anthem, on behalf of the Plan Administrator, will utilize its clinical coverage guidelines, including Anthem's medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making Medical Necessity decisions. Anthem, on behalf of the Plan Administrator, reserves the right to review and update these clinical coverage guidelines periodically. In the event of a conflict, however, this Summary Plan Description takes precedence over Anthem's clinical coverage guidelines.

As a Member, you are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your Precertification, Predetermination or Post Service Clinical Claims Review request. To request this information, contact the customer service telephone number on your Identification Card.

Review Request Categories:

- ***Urgent Review –*** A request for Precertification or Predetermination of medical care or treatment that, if the timeframe for making a non-Urgent Review decision were applied:

    (a) Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, as determined by (i) the treating Provider or any Physician with knowledge of the Member's medical condition, or (ii) Anthem, on behalf of the Plan Administrator, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or

    (b) Would, in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, subject the Member to severe pain that cannot be adequately managed without such care or treatment.

- ***Prospective Review –*** A request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.

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

- ***Retrospective Review*** - A request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements
Timeframes and requirements listed are based in general on federal regulations. You may call the customer service telephone number on your Identification Card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	As soon as possible consistent with the medical exigencies involved but in no event later than 72 hours from the receipt of request
Prospective Non-Urgent	Within a reasonable period of time appropriate to the medical circumstances but not later than15 calendar days from the receipt of the request
Concurrent when hospitalized at time of request	As soon as possible consistent with the medical exigencies involved but in no event later than 72 hours from request and prior to expiration of current certification
Other Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	As soon as possible consistent with the medical exigencies involved but in no event later than 72 hours from the receipt of the request
Concurrent Non-Urgent	No later than 15 calendar days from the receipt of the request
Retrospective	No later than 30 calendar days from the receipt of the request

Notwithstanding the timeframes listed above, Anthem will not reduce or terminate a previously approved on-going course of treatment or admission until you or your authorized representative receive notice of Anthem's decision, have an opportunity to appeal the decision and receive notice of the appeal decision.

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

Anthem, on behalf of the Plan Administrator, will provide notification of its decision in accordance with federal regulations.

Notification may be given by the following methods:

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

Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and the Member or the Member's authorized representative.

Denial of Precertification or Claim

Please see the section of this Summary Plan Description titled "**Benefit Claim and Appeals Procedures**" for notification and appeal procedures that apply if Anthem denies, in whole or in part, your request for Precertification of Plan coverage, your request for Predetermination for Plan benefits or your claim for Plan benefits.

Care Management

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

Care Management programs are confidential and voluntary. These programs are provided at no additional cost to you and do not affect Covered Services. Licensed health care professionals trained in care management and familiar with the Plan's benefits provide these services.

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

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

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider.

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

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

Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Plan payment for Covered Services will be limited by any applicable Coinsurance, Deductible, Benefit Period maximum, or lifetime Maximum Benefit in this Summary Plan Description.

Wellness Benefit

Eligible charges for routine care, including examinations, pap smears, mammograms, other related x-ray and laboratory services, immunizations and well-baby care are covered as specified on the "Schedule of Benefits". For Preventive Care services refer to the "Preventive Care Services" section.

Preventive Care Services

Preventive Care benefits may vary based on the age, sex, and personal history of the individual, and as determined appropriate by Anthem's clinical coverage guidelines. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Preventive Care is not subject to the Plan's Coinsurance or Deductible as long as you use a Network Provider and the Preventive Care either (1) is billed separately from any other care received, or (2) is not billed separately but is the primary purpose of an office visit. Please be aware that, if a Network Provider bills Preventive Care separately from an office visit, the Plan's Coinsurance or Deductible may apply to the portion of such office visit that does not constitute Preventive Care.

For example, if a Member visits a Network Provider and the primary purpose of the visit is not to receive Preventive Care, any Preventive Care received will be considered under the Diagnostic Services benefit unless the Provider bills the Preventive Care as a separate charge. For example, if a Member visits a Network Provider for the primary purpose of remedying abdominal pain and, during the office visit, the Member also receives Preventive Care, all benefits received will be considered under the Diagnostic Services benefit unless the Network Provider bills separately for the Preventive Care.

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

Some examples of Preventive Care Covered Services are:

- **Immunizations, including but not limited to**:

  Influenza virus vaccine
  Hepatitis A vaccine
  Hepatitis B vaccine
  Hemophilus influenza b vaccine (Hib)
  Diphtheria, Tetanus, Pertussis vaccine
  Mumps virus vaccine
  Measles virus vaccine
  Rubella virus vaccine
  Poliovirus vaccine
  Shingles vaccine
  Human Papillomavirus (HPV) vaccine
  Meningococcal vaccine
  Varicella (chickenpox) vaccine

- **Screening examinations, including but not limited to:**

  1. Routine screening mammograms;
  2. Routine chlamydia screening;
  3. Routine osteoporosis screening;
  4. Routine colorectal cancer examination and related laboratory tests; and
  5. Routine prostate specific antigen testing.

If you would like to verify if a service is considered Preventive Care, please contact Anthem.

Physician Office Services

Office Services include care in a Physician's office that is not related to Maternity, Mental Health, or Substance Abuse, except as specified. Refer to the sections entitled "Maternity Services" and "Mental Health/Substance Abuse Services" for services covered by the Plan. For Emergency accident or medical care refer to the "Emergency Care and Urgent Care" section. For Preventive Care services refer to the "Preventive Care Services" section.

Office visits for medical care and consultations to examine, diagnose, and treat an Illness or Injury performed in the Physician's office. Office visits include injections including allergy

injections. Sublingual drops are not covered.

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

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

Therapy Services for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other professional Provider.

Inpatient Services

Inpatient Services do not include care related to Maternity, Mental Health, or Substance Abuse, except as specified. Refer to the sections entitled "Maternity Services" and "Mental Health/Substance Abuse Services" for services covered by the Plan. Inpatient Services include:

- charges from a Hospital or other Provider for room, board and general nursing services;
- ancillary services; and
- professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- a room with two (2) or more beds;
- a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available;
- a room in a special care unit approved by Anthem, on behalf of the Plan Administrator. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services

- operating, delivery and treatment rooms and equipment;
- prescribed drugs;
- anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider;
- medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services; and
- Therapy Services.

Professional Services

- **Medical care visits** limited to one (1) visit per day by any one (1) Physician.

- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time.

- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two (2) or more Physicians during one (1) Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.

- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded.

- **Surgery and the administration of general anesthesia**.

- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Outpatient Services

Outpatient Services include **both facility and professional charges** when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. Outpatient Services do not include care that is related to Maternity or Mental Health/Substance Abuse Services, except as otherwise specified. Professional charges only include services billed by a Physician or other professional. *Refer to the sections entitled "Maternity Services" and "Mental Health/Substance Abuse Services" for services covered by the Plan.*

For Emergency accident or medical care refer to the "Emergency Care and Urgent Care Services" section.

Emergency Care (including Emergency Room Services) and Urgent Care Services

Medically Necessary Services, which Anthem, on behalf of the Plan Administrator, determines to meet the definition of Emergency Care or Urgent Care, will be covered, whether the care is rendered by a Network Provider or Non-Network Provider.

Ambulance Services

Ambulance Services are transportation by a vehicle designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals (other vehicles which do not meet this definition, including but not limited to Ambulettes, are not Covered Services):

- from your home, scene of accident or medical Emergency to a Hospital;

- between Hospitals;

- between Hospital and Skilled Nursing Facility;

- from a Hospital or Skilled Nursing Facility to your home.

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

- When ordered by an Employer, school, fire, or public safety official and the Member is not in a position to refuse.

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

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

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

Diagnostic Services

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

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Magnetic Resonance Imaging (MRI);
- CAT scans;
- Laboratory and pathology services;
- Cardiographic, encephalographic, and radioisotope tests;
- Ultrasound services;
- Allergy tests;
- Electrocardiograms (EKG);
- Electromyograms (EMG) except that surface EMG's are not Covered Services;
- Echocardiograms;
- Bone density studies;
- Positron emission tomography (PET scanning).

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

Surgical Services

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

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cosmetic surgery required as a result of accidental Injury;
- Functional repair or restoration of any body part when necessary to achieve normal body function;
- Charges for an assistant surgeon, if determined to be Medically Necessary by Anthem; and
- Charges for an elective vasectomy for a Member or covered Dependent, only when determined to be Medically Necessary due to a life threatening situation to the mother or baby as determined by the Plan Administrator.

The surgical fee includes normal post-operative care. Contact Anthem for more information on payment for multiple, bilateral, or assistant Surgical Services.

Covered Surgical Services include, but are not limited to:

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

Temporomandibular or Craniomandibular Joint disorder (TMJ)

Treatment of Temporomandibular or Craniomandibular Joint disorder, including office visits, lab, arthrogram, panoramic film and cephalometric films, physical therapy, biofeedback treatment and surgical treatment. TMJ appliances not covered.

Mastectomy Notice

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

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

Therapy Services

Coverage for Therapy Services when provided as part of Physician Office Services, Inpatient Facility Services, Outpatient Services, or Home Care Services is limited to the following:

Therapy Services

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

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following Illness, Injury, or loss of a body part.

- **Speech therapy** for the correction of a speech impairment. Speech therapy is covered only when the therapy is Medically Necessary.

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.

- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.

- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes.

- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Physical Medicine and Rehabilitation Services

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

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

Certain Therapy Services rendered on an Inpatient or Outpatient basis are limited. See the "Schedule of Benefits".

Chiropractic Care

Eligible charges for chiropractic care including examinations, spinal or cervical x-rays, manipulations are covered as specified on the "Schedule of Benefits". Maintenance care is not covered by the Plan.

Home Care Services

Services performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.);
- Diagnostic Services;
- Medical/Social Services;
- Nutritional Guidance;
- Home Health Aide Services;
- Therapy Services (Home Care Visit limits specified on the "Schedule of Benefits" for Home Care Services apply when Therapy Services are rendered in the home.);
- Medical/Surgical Supplies;
- Durable Medical Equipment;
- Prescription Drugs (only if provided and billed by a Home Health Care Agency);
- Private Duty Nursing.

Home infusion therapy follows Medical Policy guidelines and will be paid only if ordered by a Physician and considered Medically Necessary. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are

delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

Hospice care may be provided in the home or Hospice for medical, social and psychological services used as palliative treatment for patients with a terminal Illness and includes routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of twelve (12) months or less, as certified by the attending Physician.

Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.);
- Diagnostic Services;
- Physical, speech and inhalation therapies;
- Medical supplies, equipment and appliances;
- Counseling services (except bereavement counseling);
- Inpatient Confinement at a Hospice;
- Prescription Drugs obtained from the Hospice.

Human Organ and Tissue Transplant Services

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

Network Transplant Provider - A Provider that has been designated as a "center of excellence" by Anthem, on behalf of the Plan Administrator, and/or a Provider selected to participate as a Network Transplant Provider by a designee. Such a Provider has entered into a Network Transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

Non-Network Transplant Provider - Any Provider that has NOT been designated as a "center of excellence" by Anthem, on behalf of the Plan Administrator or has not been selected to participate as a Network Transplant Provider by a designee.

Transplant Benefit Period - Starts one (1) day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Transplant Case Manager for specific Network Transplant Provider information) for services received at or coordinated by a BQCT, and other PPO Network Provider or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Network Provider.

Transportation and Lodging - The Plan will provide assistance with reasonable and necessary travel expenses as determined by Anthem, on behalf of the Plan Administrator, when you obtain prior approval and are required to travel more than 50 plus miles from your residence to reach the facility and you must use commercial transportation to where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes lodging for the patient and one (1) companion at a maximum of $50 per day. Transportation and lodging costs are limited to an aggregate maximum of $10,000 per Transplant Benefit Period for Network Transplant Provider utilization only. The Plan does not cover charges for donor. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan when claims are filed. Contact Anthem for detailed information.

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

- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.

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

Note: Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact Anthem, on behalf of the Plan Administrator, to determine which Hospitals are Network Transplant Providers. (When calling customer service, ask to be connected with the Transplant Case Manager for further information.)

Medical Supplies, Durable Medical Equipment, and Appliances

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

Covered Services include, but are not limited to:

- **Medical and surgical supplies** - Syringes, needles, oxygen, surgical dressings, splints and other similar items, which serve only a medical purpose. Covered Services do not include

items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly. Prescription drugs and biologicals that cannot be self-administered and are provided, in a Physician's office.

- **Durable medical equipment** - The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of Illness or Injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. Please refer to the DME section on the "Schedule of Benefits" for more information. **Non-covered** items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, and corsets or other articles of clothing.

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

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

  Covered Services for prosthetic appliances include, but are not limited to:

  1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
  2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant)
  3. Breast prosthesis whether internal or external, following a mastectomy, and two (2) surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act;
  4. Minor devices for repair such as screws, nails, sutures and wire mesh;
  5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
  6. Intraocular lens implantation for the treatment of cataract or aphakia. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session);
  7. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract - formulae and supplies are also covered);
  8. Cochlear implant;
  9. Electronic speech aids in post-laryngectomy or permanently inoperative situations;
  10. "Space Shoes" when used as a substitute device when all or a substantial portion of the forefoot is absent;
  11. Wigs (the first one (1) following cancer treatment, not to exceed one (1) per Benefit Period).

12. Jobst stockings (not to exceed two (2) pairs per Benefit Period)

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

1. Dentures, replacing teeth or structures directly supporting teeth;
2. Dental appliances;
3. Such non-rigid appliances as garter belts, arch supports and corsets;
4. Artificial heart implants;
5. Hairpieces for male pattern alopecia (baldness);
6. Wigs (except as described above following cancer treatment).

- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part . The cost of casting, molding, fittings, and adjustments are included.

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

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

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

  Non-Covered Services include but are not limited to:

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

Accident Related Dental Services

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental Injury. "Initial" dental work to repair injuries due to an accident means

performed within 72 hours from the Injury, and treatment must be completed within 12 months from date of Injury.

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

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

Maternity Services

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, complications of pregnancy, miscarriage, and ordinary routine nursery care for a well newborn. Maternity Services also includes three (3) routine ultrasounds per pregnancy. For Preventive Care services refer to the "Preventive Care Services" section.

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

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

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

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

    1. The antepartum, intrapartum, and postpartum course of the mother and infant;
    2. The gestational stage, birth weight, and clinical condition of the infant;
    3. The demonstrated ability of the mother to care for the infant after discharge; and
    4. The availability of postdischarge follow-up to verify the condition of the infant after discharge.

NOTICE: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Infertility Services

Benefits include Inpatient Services, Outpatient Services, and Physician Office Services for the diagnosis or treatment of Infertility. Covered services include diagnostic and exploratory procedures to determine Infertility including surgical procedures to correct the medical diagnosed disease or condition of the reproductive organs including but not limited to, endometriosis, collapsed/clogged fallopian tubes or testicular failure. Treatment does not include in-vitro fertilization and related services, artificial insemination, reversion of surgically induced infertility, or surrogate maternity benefits. See the "Schedule of Benefits" for benefit limitations and Coinsurance amounts.

Mental Health/Substance Abuse Services

Covered Services include but are not limited to:

- **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. Precertification through Anthem or Anthem's Subcontractor is required for inpatient services.

- **Residential treatment** – individualized and intensive treatment in a licensed Residential Treatment Center/Facility, including observation and assessment by a psychiatrist weekly or more frequently, rehabilitation therapy, and education. Precertification through Anthem or Anthem's Subcontractor is required for residential treatment.

- **Partial hospitalization** – structured, multidisciplinary behavioral treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week. Precertification through Anthem or Anthem's Subcontractor is required for partial hospitalization.

- **Intensive Outpatient treatment or day treatment** – structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week. Precertification through Anthem or Anthem's Subcontractor is required for Intensive Outpatient treatment.

- **Outpatient treatment, or individual or group treatment** – office-based services, for example diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed Mental Health professional and is coordinated with the psychiatrist.

- **ADD/ADHD** – Covered under Mental Health. This also includes the following diagnosis:

developmental delays, autistic disease, learning disabilities, hyperkinetic syndromes, or intellectual disabilities.

For Preventive Care services refer to the "Preventive Care Services" section.

Non-Covered Mental Health/Substance Abuse Services:

- Custodial or Domiciliary Care.
- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets Anthem's Medical Necessity criteria for Inpatient admission for your condition.

The Plan encourages you to contact the Mental Health/Substance Abuse Services Subcontractor to verify the use of appropriate procedures, setting, and Medical Necessity. When you obtain prior approval from the Mental Health/Substance Abuse Services Subcontractor and receive services from the Provider designated by that approval, Covered Services will be considered a Network service. If you do not obtain prior approval, Covered Services will be considered a Non-Network service.

Coinsurance and limits are specified on the "Schedule of Benefits".

Skilled Nursing Facility

Eligible charges for care rendered in a licensed Skilled Nursing Facility are covered as specified on the "Schedule of Benefits". The Member must enter a licensed Skilled Nursing Facility within 24 hours after discharge from a Hospital Confinement or a related Confinement in a Skilled Nursing Facility. Care must be Medically Necessary as certified by the attending Physician every seven days and must be for the same condition as treated in the Hospital or previous Skilled Nursing Facility. The daily rate will not exceed the rate established for such care by the Department of Health and Human Services.

Orthoptic/Vision Therapy

Eligible charges for orthoptic/vision therapy are covered as specified on the "Schedule of Benefits".

Sleep Studies

Eligible charges for sleep studies are covered as specified on the "Schedule of Benefits".

Nutritional Counseling

Eligible charges for nutritional counseling are covered as specified on the "Schedule of Benefits". Certain conditions such as high cholesterol / dyslipidemia, adult and pediatric weight management, hypertension, diabetes, gestational diabetes, renal insufficiency, esophageal reflux, or failure to thrive (adult and pediatric) are just some of the medical conditions nutritional

counseling are used for. Services must be Medically Necessary. For Preventive Care services refer to the "Preventive Care Services" section.

Biofeedback Treatment

Eligible charges for biofeedback are covered as specified on the "Schedule of Benefits".

Oral Surgery

Eligible charges are covered, but not limited to, the following oral surgical procedures:

1. surgical exposure or extraction of impacted wisdom teeth;
2. excision of exostosis of the jaw and hard palate;
3. removal of tumors or cysts of the jaw, cheeks, tongue, or the roof or floor of the mouth, (does not include the removal of tumors or cysts related to gums and teeth);
4. treatment of accidental Injuries to natural teeth including replacement of such natural teeth. However, treatment must be rendered within 72 hours of the accidental Injury and treatment must be completed 12 months from the date of the Injury;
5. apicoectomy - excision of apex of tooth root, but not to include root canals;
6. external incision and drainage of cellulitis, not including those related to gums and teeth;
7. incision of accessory sinuses, salivary glands or ducts;
8. gingivectomy - excision of loose gum tissue to eliminate infection;
9. alveolectomy - the leveling of structures supporting teeth for the purpose of fitting dentures;
10. frenectomy - the cutting of the tissue in the tongue's midline in order to alleviate tongue-tie;
11. osseous surgery;
12. treatment of facial and jaw fractures;
13. surgery related to temporomandibular joint dysfunction; and
14. osteotomies, with or without LaForte.

EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of Exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The following charges are not Covered Services under the Plan. No medical benefits will be paid with respect to them, except as specified:

1. charges due to an Illness or Injury which results from war, declared or undeclared, and/or armed aggression by the military forces of any country or combination of countries or any act incident to war;

2. charges related to claims arising out of, or in any course of any occupation or employment for wage or profit or claims for which the Member is entitled to benefits under any Workers' Compensation or occupational disease law, whether benefits are claimed or not. This exclusion shall not apply to a Member who is not required by State Law to be covered by Workers' Compensation or Occupational Disease Law or similar legislation;

3. charges or expenses for which the Member (or the Member's parent or guardian in the instance of a minor Dependent) is not legally bound or obligated to pay or which are for medical care furnished without charge, paid for, or reimbursable by or through the government of a nation, state, province, county, municipality or other political subdivision, or instrumentality or agency of such government. This limitation will not apply where specifically prohibited by applicable statute;

4. charges made by a Veteran's Administration Hospital or a Hospital operated by one (1) of the Uniformed Services for a service related condition;

5. charges made by a person, Hospital, or entity normally making no charge for medical care, regardless of the patient's financial ability, if the patient has no insurance for medical care. This limitation will not apply where specifically prohibited by applicable statutes;

6. charges for routine eye care, eyeglasses, contact lenses, or charges for the fitting of eyeglasses or contact lenses, radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy, or any surgical variation, which is performed for the sole purpose of correcting nearsightedness or far-sightedness, night vision appliances;

7. charges for routine hearing checks, hearing aids or hearing aids and related services, the extent such services do not constitute Preventive Care;

8. charges for personal comfort items including television and telephone;

9. charges for TMJ appliances/splints, orthodontic therapy and oral equilibration therapy for all conditions including temporomandibular joint dysfunction;

10. charges for the treatment of an Illness or Injury resulting from the commission of, or attempt to commit by the Member, a felony or aggravated battery, unless the Injury or

Illness results from an act of domestic violence or medical condition (which includes both a physical condition and/or Mental Health or Substance Abuse);

11. charges for personal hygiene and convenience items;

12. charges incurred before the effective date or after the termination date of a Member's coverage;

13. charges for (a) failure to keep a scheduled visit, (b) telephone or internet consultations (other than charges for Covered Services provided by LiveHealth Online Providers), or (c) completion of claim forms or return to work or school forms;

14. charges received by the Plan more than 12 months after the date of service;

15. charges for the purchase or rental of: exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers, heel lifts, batteries for any use, or garage door openers;

16. charges for treatment of infertility and fertility enhancements, including in-vitro fertilization, artificial insemination or any other artificial means of conception, transsexual surgery, or treatment, and treatment of sexual dysfunction not related to organic disease, and charges for a surrogate mother. Procedures designed to reverse elective or Medically Necessary sterilizations are not covered;

17. charges made by a Hospital for a private room, unless otherwise specified by the Plan;

18. charges for smoking cessation, including deterrents, to the extent such services do not constitute Preventive Care;

19. charges for treatment of temporomandibular joint dysfunction (TMJ), unless specified otherwise by the Plan;

20. charges for a grandchild of the Worker, unless the grandchild meets the definition of a Dependent specified in the Plan;

21. charges in excess of any Maximum Benefit amounts specified on the "Schedule of Benefits";

22. charges for services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group if such department is maintained to provide services primarily for the benefit of the employees of such employer or the members of such association, union, trust, etc;

23. charges for an elective abortion;

24. charges for vasectomies, unless Medically Necessary due to a life threatening situation to the mother or baby as determined by the Plan Administrator;

25. charges for female sterilizations;

26. charges for the birth of a child in a home delivery setting. Charges for pre-natal and post natal care will be covered if performed by a certified nurse midwife or an M.D.;

27. charges for contraceptive medications and devices;

28. charges for OB risk assessments;

29. charges for wigs or hair prosthesis, unless otherwise specified in the Plan;

30. charges which are reimbursable through medical coverage provided by or available through any applicable "No-Fault" automobile law or coverage, (except for those who reside in the state of Michigan), or any other automobile, homeowners, aircraft, boat owners, or similar policy of insurance;

31. charges for prescription drugs, medications, or supplies except those which are administered in or dispensed at a Physician's office, a Hospital, Skilled Nursing Facility or other Inpatient setting;

32. charges for orthotics, castings for shoe orthotics and related services, unless otherwise specified in the Plan;

33. charges for corrective shoes (unless an integral part of a brace or for diabetic conditions);

34. charges by any provider or facility for Prospective Review or Concurrent Review;

35. charges for third party examinations and treatments, such as those requested for employment, or purchase of insurance;

36. charges for examinations and all related services which are performed pursuant to state statute or regulation, unless the Injury or Illness results from an act of domestic violence or medical condition (which includes both a physical condition and/or Mental Health or Substance Abuse);

37. charges for a response for information that may be required by the Plan in order to process claims. The Plan has the right to deny claims submitted for benefit payment if such information is not received. (Please contact Anthem if you have questions regarding the required information);

38. any charge that is not a covered expense under the Plan;

39. charges for prosthetic devices and durable medical equipment which do not meet the requirements in the definition "Medically Necessary" in the Definitions section of the Plan;

40. charges for routine whole body or heart scans;

41. charges for services from any provider who has been identified for billing irregularities;

42. charges for services, equipment, supplies, human organ and tissue transplants, prescription drugs or medications which are determined not Medically Necessary or do

not meet Anthem's medical policy, clinical coverage guidelines, or benefit policy guidelines;

43. charges received from an individual or entity that is not a Provider, as defined in this Summary Plan Description or recognized by the Plan;

44. charges for services, equipment, supplies, human organ and tissue transplants, prescription drugs or medications which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative services, equipment, supplies, human organ and tissue transplants, prescription drugs or medications, as determined by Anthem, on behalf of the Plan Administrator;

45. charges for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident;

46. charges for care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation;

47. charges for prescription drug copayments or deductibles the Member is responsible for under other coverage with other carriers or health plans;

48. charges for membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results;

49. charges for court ordered testing or care;

50. charges prescribed, ordered, or referred by, or received from a Family Member or a person who resides in the home of a Member;

51. charges for medical records or reports unless otherwise required by law;

52. charges for mileage costs or other travel expenses, except as authorized by Anthem, on behalf of the Plan Administrator;

53. charges in excess of the Maximum Allowable Amount;

54. charges for any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law;

55. charges for Custodial Care, Domiciliary Care or convalescent care, whether or not recommended or performed by a professional;

56. charges for foot care only to improve comfort or appearance including, but not limited to care for flat feet, subluxations, corns, calluses, and toenails except when Medically Necessary including but not limited to, foot care for diagnosis of diabetes or for impaired circulation to the lower extremities;

57. charges for any treatment of teeth, gums or tooth related service, including dental implantology, except as otherwise specified as covered in this Summary Plan Description;

58. charges related to weight loss or weight loss programs whether or not they are under medical or Physician supervision, to the extent such programs do not constitute Preventive Care. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity, to the extent such programs do not constitute Preventive Care;

59. charges for services or supplies primarily for educational, vocational, or training purposes;

60. charges for expenses incurred at a health spa or similar facility;

61. charges for self-help training and other forms of non-medical self care;

62. charges for examinations relating to research screenings;

63. charges for Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility;

64. charges for Private Duty Nursing Services except when provided through the Home Care Services benefit;

65. charges for services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

66. charges for drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;

67. charges for sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy;

68. charges for treatment of telangiectatic dermal veins (spider veins) by any method;

69. charges for drugs in quantities which exceed the limits established by the Plan;

70. charges for the following Mental Health/Substance Abuse Services:

- Custodial or Domiciliary Care.
- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets Anthem's Medical Necessity criteria for Inpatient admission for your condition.

PRESCRIPTION DRUG BENEFITS

Express Scripts, Inc. will administer eligible claims for the prescription drug benefits that are not Covered Services. All such prescription drug claims should be submitted directly to Express Scripts for reimbursement, subject to the terms of this prescription drug benefit program. (**Note:** Claims for prescription drugs that are Covered Services are administered by Anthem.)

Under this benefit, the Member is responsible for the Deductible as specified on the "Schedule of Benefits". After satisfaction of the listed Deductible, eligible charges are covered at 100%.

For additional information regarding your prescription drug program, including a listing of eligible and ineligible drugs, please contact the customer service department at Express Scripts, Inc. at the number listed below.

The prescription drug benefit applies if the Member has the prescription filled by a participating pharmacy. If the Member is unable to locate a participating pharmacy, the prescription along with a completed claim form, should be submitted directly to Express Scripts, Inc. at the following address:

Express Scripts, Inc.
P.O. Box 14711
Lexington, KY 40512
1-800-818-6634

VISION CARE BENEFITS

Vision Service Plan (VSP) will administer the Vision Care program. All routine vision care claims should be submitted directly to VSP for reimbursement.

For additional information regarding your vision care program, including a listing of network providers, covered services and schedule of benefits, please contact the customer service department at VSP at the number listed below.

The vision care benefit applies if the Member obtains the covered service or item at a network provider. If the Member obtains the covered service or item at a non-network provider, the itemized receipt along with a completed claim form should be submitted directly to VSP at the following address:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018
1-800-877-7195

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Therefore, provisions below regarding "Claim Forms" and "Notice of Claim" do not apply, unless the claim was not filed by the Provider.

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim use a claim form.

How Benefits Are Paid

The Plan shares the cost of your medical expenses with you up to the amount of the Maximum Allowable Amount. For services subject to a Deductible, you pay a portion of the bill before the Plan begins to pay its share of the balance. Some services are subject to Coinsurance, others may be subject to both a Deductible and Coinsurance.

Network Providers will seek compensation from the Plan for Covered Services. When using a Network Provider you are only responsible for Coinsurance, Deductibles, and non-covered charges. Network Providers have agreed to accept the Maximum Allowable Amount as payment in full. If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the actual charge billed and the Maximum Allowable Amount plus any Deductible, Coinsurance, and non-covered charges. For Covered Services subject to Coinsurance, you pay a portion of the bill and the Plan pays its share of the balance. Refer to the "Schedule of Benefits" to see what Coinsurance is required for each Covered Service.

The amount you pay may differ by the type of service you receive or by Provider. Refer to the "Schedule of Benefits" to see what amount you are required to pay for each service. Claims for Covered Services do not need to be sent to Anthem in the same order that expenses were incurred.

If you receive Covered Services in a Network Provider facility from a Non Network Provider such as an anesthesiologist who is employed by or contracted with that Network Facility, benefits will be paid. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full under a Network Provider's participation agreement for this Plan, except to the extent necessary to comply with 29 CFR § 2590.715-2719A(b) (regarding Emergency Hospital Care). You may be liable for the difference between the billed charge and the Maximum Allowable Amount. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

Anthem, on behalf of the Plan Administrator, will deny that portion of any charge which exceeds the Maximum Allowable Amount.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one (1) service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowable Amount. **If services are performed by Non-Network Providers,** then you are

responsible for any amounts charged in excess of the Plan's Maximum Allowable Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact Anthem for more information.

Payment of Benefits

You authorize Anthem, on behalf of the Plan, to make payments directly to Providers for Covered Services. Anthem, on behalf of the Plan, also reserves the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Anthem, on behalf of the Plan, will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by ERISA or any applicable state or Federal law.

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

Assignment

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

Notice of Claim

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

If Anthem has not received the information it needs to process a claim, Anthem will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, Anthem cannot complete the processing of the claim until the additional information requested has been received. Anthem generally will make its request for additional information within 30 days of Anthem's initial receipt of the claim and will complete its processing of the claim within 15 days after Anthem's receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Anthem notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of initial claim, nor additional information on a claim can be submitted later than one (1) year after the date of service, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for

claim forms to Anthem or the Plan Administrator, or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Anthem without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient;
- Patient's relationship with the Covered Worker;
- Identification number;
- Date, type and place of service;
- Your signature and the Physician's signature.

Time Benefits Payable

The Plan will pay all benefits for Covered Services within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If Anthem has not received the information needed to process a claim, Anthem, on behalf of the Plan Administrator, will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, Anthem cannot complete the processing of the claim until the additional information requested has been received. Anthem, on behalf of the Plan Administrator, generally will make a request for additional information within 30 days of Anthem or the Plan Administrator's initial receipt of the claim and will complete processing of the claim within 15 days after Anthem's receipt of all requested information.

At the Plan Administrator's discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, the Plan may reimburse those other parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to Anthem, on behalf of the Plan Administrator, such authorizations, consents, releases, assignments and other documents as may be requested by Anthem, in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program.

Explanation of Benefits

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

- Total amounts charged for services/supplies received;

- The amount of the charges satisfied by your coverage;

- The amount for which you are responsible (if any).

- General information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

BlueCard

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

- The billed charges for your Covered Services, or

- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto Anthem, on behalf of the Plan Administrator.

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

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

If you obtain services in a state with more than one (1) Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the customer service number on your ID card or go to www.anthem.com for more information about such arrangements.

Denial of Claim

Please see the article titled "**Benefit Claim and Appeals Procedures**" for notification and appeal procedures if your claim is denied.

GENERAL TERMS AND DEFINITIONS

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

Actively at Work or **Active Work** - the Worker is at work and performing the regular duties of the Worker's position for his/her Employer.

A Worker is considered to be Actively at Work for the Employer on: (a) each day of regular paid vacation; (b) each regular non-working day, provided in each instance that the Worker was actively at work on the last regular work day preceding the absence; (c) any day a Worker is covered under the Plan by virtue of a leave as described in the Plan (other than a FMLA leave); (d) any day a Worker is on an FMLA leave; or (e) for purposes of determining a Worker's Date of Employment, any day on which a Worker is absent from employment with the Employer due to a health factor of the Worker.

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

Adverse Benefit Determination - a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit that is based on:

- Eligibility to participate in the Plan;
- A determination that a benefit is not a Covered Service;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is Experimental/Investigative, or not Medically Necessary or appropriate.

Failure to make a payment in whole or in part includes any instance where the Plan pays less than the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to the terms of the Plan regarding Coinsurance, Deductibles, or other cost-sharing requirements. An Adverse Benefit Determination also includes any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at that time.

Affiliated Agencies - Organizations under the supervision of Member Congregations, or any other Lutheran organization in fellowship with the Synod, including Northwestern Publishing House, Wisconsin Lutheran Child and Family Service, Synodical Schools, area Lutheran high schools and charitable agencies, the Evangelical Lutheran Synod and its member congregations, schools and agencies, all as set forth in the Synod Yearbook. The VEBA Commission determines eligibility for participation in the Plan.

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

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be

authorized after the service is rendered) by Anthem, on behalf of the Plan Administrator, to be paid at the Network level.

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

Calendar Year - The period from January 1 through December 31 of the same year.

Certificate of Creditable Coverage - A written document that discloses the Worker's and Dependent's Creditable Coverage under a group health plan or health insurance.

COBRA Coverage - Coverage offered to comply with the requirements of section 4980B of the Internal Revenue Code and section 601 of the Employee Retirement Income Security Act of 1974 and described under Section D of the Article of the Plan titled "Continuation of Coverage."

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services that is indicated on the "Schedule of Benefits," which you must pay. See the "Schedule of Benefits" for any exceptions.

Confinement - The period of time in which a Member is registered as an Inpatient for which a room and board charge is made. Confinement begins with admission and ends with discharge.

Coverage Option - The Plan health benefit coverage option selected by the Covered Worker. The Plan offers the following Coverage Options:

a) *Employee Only Coverage*—under which the Plan covers only the Covered Worker.

b) *Employee plus Spouse Coverage*—under which the Plan covers only the Covered Worker and the Covered Worker's Spouse, subject to timely completion of associated enrollment materials.

c) *Employee plus Non-Spouse Dependent Coverage*—under which the Plan covers the Covered Worker and the non-Spouse Dependents of the Covered Worker, subject to timely completion of associated enrollment materials, but does not cover the Spouse of the Covered Worker.

d) *Family Coverage*—under which the Plan covers the Covered Worker and all of the Covered Worker's Dependents, subject to timely completion of associated enrollment materials.

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

- Medically Necessary or otherwise specifically included as a benefit under this Summary Plan Description.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.

- Not Experimental/Investigative or otherwise excluded or limited by this Summary Plan Description, or by any amendment or rider thereto.

- Authorized in advance by Anthem, on behalf of the Plan Administrator, if such Prior Authorization is required in the Plan.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Anthem, on behalf of the Plan Administrator, including necessary acquisition costs and preparatory myeloblative therapy.

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

Covered Worker - A Worker who is enrolled in and covered by the Plan.

Creditable Coverage - Coverage under a health plan as defined in 29 CFR §2590.701-4(a).

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

- assistance with walking, bathing, or dressing;

- transfer or positioning in bed;

- normally self-administered medicine;

- meal preparation;

- feeding by utensil, tube, or gastrostomy;

- oral hygiene;

- ordinary skin and nail care;

- catheter care;

- suctioning;

- using the toilet;

- enemas; and

- preparation of special diets and supervision over medical equipment or exercises or over self-

administration of oral medications not requiring constant attention of trained medical personnel.

Date of Employment - The date:

- The Worker is hired or called by an Employer, is available to provide service and reports to Active Work.
- If the Worker is a student who is covered by this Plan, Date of Employment means the end of the month in which the student is no longer a Dependent. If the Worker is a student covered by another health plan, Date of Employment means the day the student loses dependent status under that plan.

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

Dependent - One of the following individuals:

A. The Spouse of a Worker.

B. The child of a Worker [including the Worker's natural child, adopted child (i.e., effective as of the date of adoption or, if earlier, the date the child is placed for adoption with the Worker), or stepchild], provided one of the following conditions is satisfied:

1. The child is under age 26; or

2. The child is age 26 or older and the Worker provides more than one-half of the financial support for the child because the child is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and:

a) the condition began before the child would otherwise lose Dependent status under the Plan; and

b) the child has been continuously covered by the Plan.

C. The child of a Dependent for the period of time that the Worker provides more than one-half the financial support of the child **and** the child is the Worker's dependent for federal income tax purposes.

For purposes of this Plan, the term "Dependent Child" means a Dependent of a Worker described in B or C above.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. "Diagnostic Service" includes a test performed as a Medically Necessary preventive care screening for an asymptomatic patient that does not otherwise qualify as Preventive Care. It must be ordered by a Provider. A Diagnostic Service does not include any service that constitutes Preventive Care. Covered Diagnostic Services are limited to those services specifically listed in the "Covered Services" section.

Disabled Worker Coverage - Coverage continued under Section C of the Article of the Plan titled "Continuation of Coverage."

Domiciliary Care - Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and

consisting chiefly of room and board, even if therapy is included.

Effective Date of the Plan - January 1, 2008.

Emergency Medical Condition (Emergency) - An accidental traumatic bodily Injury or other medical condition that manifests itself by acute symptoms of such 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:

- 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;

- result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care - Covered Services, including services that constitute Emergency Hospital Care, that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

Emergency Hospital 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

- Further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required to assure, within reasonable medical probability, that no material deterioration of the Emergency Medical Condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition concerning a pregnant woman who is having contractions, to deliver (including the placenta).

Employer - The Sponsoring Organization that employs the Worker**.**

Experimental/Investigative - Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, Illness, or other health condition which Anthem or Anthem's designee, on behalf of the Plan Administrator, determines in its sole discretion to be Experimental/Investigative. Anthem, on behalf of the Plan Administrator, will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if Anthem, on behalf of the Plan Administrator, determines that one (1) of more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought:

The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;

- has been determined by the FDA to be contraindicated for the specific use; or

- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;

- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one (1) or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- documents of an IRB or other similar body performing substantially the same function; or

- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- medical records; or

- the opinions of consulting Providers and other experts in the field.

Family Member - A Member's Spouse, child, parent, brother, sister and any other eligible Dependent as described by the Plan.

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

Illness - Pregnancy or a disease or disturbance in the function or structure of the body which causes physical signs and/or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or systems of the body.

Injury - A condition caused by accidental means and from an external force which results in damage to the Member's body from an external force.

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

Loss of Eligibility - A "Loss of Eligibility" as defined in 29 CFR §2590.701-6(a)(3)(i) and includes a situation in which an individual is no longer eligible for coverage under the health Plan due to divorce, legal separation, death, loss of Dependent status, termination of employment or reduction of hours, or reaching the lifetime cap on benefits. The decision not to continue paying premiums under the other health Plan or termination of coverage for cause is <u>not</u> considered a Loss of Eligibility.

Maximum Allowable Amount - The amount that Anthem or Anthem's Subcontractor determines, on behalf of the Plan Administrator, is the maximum payable for Covered Services you receive, up to but not to exceed charges actually billed. Generally, to determine the Maximum Allowable Amount for a Covered Service, Anthem or Anthem's Subcontractor use internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider, the Maximum Allowable Amount is equal to an amount negotiated by Anthem with that Non-Network Provider for Covered Services under this product or any other product. In the absence of a negotiated amount, Anthem shall have discretionary authority to establish as Anthem deems appropriate, the Maximum Allowable Amount for a Non-Network

Provider. The Maximum Allowable Amount is the lesser of the Non-Network Provider charge, or an amount determined by Anthem, after consideration of any one (1) or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that Anthem may have made, or other factors Anthem deems appropriate. It is your obligation to pay any Coinsurance and Deductibles, and any amounts which exceed the Maximum Allowable Amount.

For Emergency Hospital Care obtained from a Non-Network Provider, the Maximum Allowable Amount is an amount calculated under 26 CFR § 54.9815-2719AT(b), equal to the greatest of (1) the median Network Provider rate; (2) the Usual, Customary and Reasonable Charges, or (3) the Medicare rate.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with Anthem.

Maximum Benefit - The total eligible charges that the Plan will pay per Member while that Member is covered by the Plan.

Medically Necessary or **Medical Necessity -** Health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medicare - The program for health benefits under Title XVIII of the Social Security Act as amended.

Member - Any of the following individuals:

A. The Covered Worker;

B. The Covered Worker's Dependents when enrolled and covered for health benefits under the Plan;

C. An individual covered under the Plan pursuant to one of the following articles of the Plan:
    1. Leave of Absence
    2. Continuation of Coverage

The term "Member" shall include the individuals identified in the definition of Member unless otherwise indicated.

Member Congregations - The individual congregations listed in the "directory of congregations" in the annual Synod Yearbook.

Mental Health - Mental, nervous or emotional disease or disorders of any type as classified in the most current version of the International Classification of Diseases, in the chapter titled "Mental Disorders". This is true regardless of the original cause of the disorder. (Note: Substance Abuse shall not be deemed a Mental Health condition for purposes of this Plan.)

To determine what is classified as Mental Health, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

Mental Health/Substance Abuse Subcontractor - An organization or entity that Anthem has a contract with to provide administrative and claims payment services and/or Covered Services regarding Mental Health/Substance Abuse services under this Plan. These administrative services may also be provided directly by Anthem.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Anthem, or with another organization which has an agreement with Anthem, regarding payment for Covered Services and certain administration functions for the Network associated with the Plan.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Anthem or with another organization which has an agreement with Anthem to provide Covered Services and certain administrative functions to you for the network associated with this Summary Plan Description. A Hospital may be a Network Transplant Facility with respect to:

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

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

New FDA Approved Drug Product or Technology does not include:

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

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

Non-Network Transplant Facility - Any Hospital which has not contracted with the transplant network engaged by Anthem to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or

- All Covered Transplant Procedures.

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

Pharmacy and Therapeutics 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 - The group health High Deductible Plan Option under the WELS VEBA Group Health Care Plan, as set forth in this document (including all its schedules, provisions, exclusions, limitations, and appendices), as amended from time to time.

Plan Administrator, or **Administrator** - The VEBA Commission, which is responsible for administering the Plan, as provided in the "Plan Administration and Interpretation" section. The WELS Benefit Plans Office provides services on behalf of the Plan Administrator**.**

Plan Sponsor - The Wisconsin Evangelical Lutheran Synod**.**

Plan Year - The 12-month period beginning January 1st and ending December 31st.

Post-Service Claim – A claim for benefits under the Plan for which you have received the service.

Pre-Service Claim – A claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.

Preventive Care - Any of the following items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (for this purpose, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current);

(ii) With respect to women, to the extent not described in the preceding paragraph, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;

(iii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention); and

(iv) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Services related to a recommendation or guideline referenced above shall not be considered "Preventive Care" until the later of January 1, 2011, or the first day of the first Plan Year that begins on or after the date that is one year after the date the recommendation or guideline is issued. If a recommendation or guideline ceases to be referenced above, services related to that recommendation or guideline shall not constitute "Preventive Care." The foregoing notwithstanding, "Preventive Care" does not include contraceptive medications or devices.

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

Private Duty Nursing Services - Private Duty Nursing (PDN) Services include only Skilled Nursing Services ordered by a Physician and rendered in the home or as an Inpatient by a practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). Skilled Nursing Services do not include Custodial Care or services, which could be performed by the average non-medical person with proper training even if ordered by Physician. (See the definitions of Skilled Nursing Services and Custodial Care for examples of care which are not covered.) PDN Services are limited to the amount shown on the "Schedule of Benefits".

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities:

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);

  2. Surgery;

  3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A Provider that:

  1. is licensed as such, where required;

2. is equipped mainly to do Surgery;

3. has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present;

4. is not an office maintained by a Physician for the general practice of medicine or dentistry; and

5. is equipped and ready to initiate Emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:

  1. constituted, licensed, and operated as set forth in the laws that apply;

  2. equipped to provide low-risk maternity care;

  3. adequately staffed with qualified personnel who:

     a. provide care at childbirth;

     b. are practicing within the scope of their training and experience; and

     c. are licensed if required; and

  4. equipped and ready to initiate Emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

2. has a staff with one (1) or more Physicians available at all times;

3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an Illness or Injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

1. nursing care;

2. rest care;

3. convalescent care;

4. care of the aged;

5. Custodial Care;

6. educational care;

7. treatment of alcohol abuse; or

8. treatment of drug abuse.

- **Physician -**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

   a. covered by the Plan;

   b. required by law to be covered when rendered by such practitioner; and

   c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Residential Treatment Center/Facility** - A Provider licensed and operated as required by law, which includes:

1. room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability;

2. a staff with one or more doctors available at all times;

3. residential treatment takes place in a structured facility-based setting;

4. the resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder;

5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care; and

6. is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

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

1. nursing care;
2. rest care;
3. convalescent care;
4. care of the aged;
5. Custodial Care; or
6. educational care.

- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. mainly provides Inpatient care and treatment for persons who are recovering from an Illness or Injury;

  2. provides care supervised by a Physician;

  3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

  4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

  5. is not a rest, educational, or custodial Provider or similar place.

- **Urgent Care Center -** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Medical Child Support Order - Any judgment, decree or order, including approval of a settlement agreement, issued by a court that:

a) Provides for child support or health benefit coverage with respect to a child of a Member, is made pursuant to a state domestic relations law (including community property law) and relates to benefits under the Plan; or

b) Enforces a law relating to medical child support with respect to a group health Plan described in section 1908 of the Social Security Act.

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

Retired Worker - A Covered Worker who ceases to be a Worker and continues coverage under Section B of the Article of the Plan titled "Continuation of Coverage."

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

Service in the Uniformed Services - The performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Skilled Care - Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an Illness or Injury. It is ordered by a Physician and usually involves a treatment plan.

Sponsoring Organizations - The Synod, Member Congregations and Affiliated Agencies.

Spouse - Except as provided in the following sentence, "Spouse" means the Spouse of an individual as determined under the laws of the individual's state of residence. The previous sentence notwithstanding, the "Spouse" of an individual shall not include anyone who is the same gender as that individual.

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

- your discharge from an Emergency department or other care setting where Emergency Care is provided to you;

- your transfer from an Emergency department or other care setting to another facility; or

- your transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor - Anthem and/or the Plan Administrator may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and Mental Health/behavioral health and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Anthem or the Plan Administrator's behalf.

Substance Abuse - The use of a psychoactive substance in a manner detrimental to society or the Member and which meets, or with continued use may meet, criteria for substance abuse or drug dependency.

Summary Plan Description - This booklet which summarizes the benefits under this Plan to which the Member is entitled. The booklet is intended to satisfy the requirements of a Summary Plan Description, as specified in ERISA, and may be amended from time to time.

Surviving Spouse Coverage - Coverage offered under Section A of the Article of the Plan titled "Continuation of Coverage."

Synod - The Wisconsin Evangelical Lutheran Synod.

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

Third Party Administrator - An organization or entity that the Plan Administrator contracts with to provide administrative and claims payment services under the Plan. The Third Party Administrator is Anthem Insurance Companies, Inc. The Third Party Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Totally Disabled - A Covered Worker is "Totally Disabled" if the Covered Worker is eligible to receive long-term disability benefits under the long-term disability insurance plan sponsored by the Synod.

Trust - The trust that the Synod established to fund Plan benefits.

Uniformed Services - The Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in the time of war or emergency.

VEBA Commission - The committee appointed by Synod that is responsible for the maintenance and administration of the Plan.

Worker - The following employees, called individuals and Synodical students:

A. A person who is hired, or called, and compensated by any Sponsoring Organization, but excluding persons employed on a special, probationary, part-time or temporary basis. For purposes of the Plan:

1. "Part-time basis" means customarily less than 20 hours a week; and

2. "Temporary basis" means customarily less than 5 months a year.

B. Students who have attained age 19 and are enrolled in a Synodical school for the primary purpose of entering into a full-time teaching or preaching ministry.

The Plan Administrator, in its sole discretion, shall determine who qualifies as a "Worker." Any classification, reclassification or other characterization of any individual as a Worker of the

Synod or a Sponsoring Organization, whether as a statutory, common law employee or otherwise, by a court of law or by action of any federal, state or local governmental agency shall not affect the exclusion of such individual from participation in the Plan. Any individual whom the Plan Administrator determines is not a Worker shall not be treated as a Worker hereunder solely because he/she has been classified or reclassified as a Worker or employee of the Synod or a Sponsoring Organization by any court or government agency.

GENERAL PROVISIONS

Disagreement with Recommended Treatment

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

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

Circumstances Beyond the Control of the Plan

Anthem, on behalf of the Plan Administrator, shall make a good-faith effort to arrange for an alternative method of administering benefits in the event of circumstances not within the control of Anthem or the Plan Administrator, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of Anthem, disability of a significant part of a Network Provider's personnel or similar causes. In such event, Anthem and Network Providers shall administer and render services insofar as practical, and according to their best judgment; but Anthem and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. The Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Plan Administrator's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As a Third Party Administrator of the Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the customer service number on the back of your Identification Card.

Privacy and Security of Protected Health Information

1. Plan's Use of Protected Health Information.

The Plan will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by HIPAA. PHI is individually identifiable health information that is transmitted or maintained in any form or medium — electronic, oral or written. Health information means any information, including genetic information, that is

created or received by the Plan that relates to: 1) the past, present or future physical or mental health or condition of an individual, 2) the provision of health care to an individual, or 3) the past, present or future payment for the provision of health care to an individual. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Member inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management,

contacting health care providers and patients with information about treatment alternatives and related functions;

- rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

- business management and general administrative activities of the Plan, including, but not limited to management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; and,

- resolution of internal grievances.

2. Disclosures to the Plan Sponsor

(a) *Plan Sponsor's Certification of Compliance.* Neither the Plan nor any business associate servicing the Plan will disclose Members' PHI, including any Electronic Protected Health Information, as defined by 45 CFR§160.103, to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Document has been amended to incorporate this section 2, and agrees to abide by this section.

(b) *Purpose of Disclosure to Plan Sponsor.*

(i) The Plan and any business associate servicing the Plan will disclose Members' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the HIPAA and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Plan Sponsor of Members' PHI will be subject to and consistent with the provisions of paragraphs (c) and (d) of this section.

(ii) Neither the Plan nor any business associate servicing the Plan will disclose Members' PHI to the Plan Sponsor unless the disclosures are explained in the Privacy Practices Notice distributed to Members.

(iii) Neither the Plan nor any business associate servicing the Plan will disclose Members' PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(c) *Restrictions on Plan Sponsor's Use and Disclosure of PHI.*

(i) The Plan Sponsor will neither use nor further disclose Members' PHI, except as permitted or required by this Plan document, as amended, or as required by law.

(ii) The Plan Sponsor will ensure that any agent, including any subcontractor, to which it provides Members' PHI agrees to the restrictions and conditions of this Plan document,

including this section 2, with respect to Members' PHI, including implementation of reasonable and appropriate security measures to protect such PHI in accordance with 45 CFR §164.314(b)(2)(iii).

(iii) The Plan Sponsor will not use or disclose Members' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(iv) The Plan Sponsor will report to the Plan any use or disclosure of Members' PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure. Additionally, pursuant to 45 CFR §164.314(b)(2)(iv), the Plan Sponsor will report to the Plan any security incident of which it becomes aware, under the following conditions. If a security incident results in an actual disclosure of PHI not permitted herein, the Plan Sponsor will report such incident to the Plan. The Plan Sponsor will report to the Plan any unauthorized: (1) access, use, disclosure, modification, or destruction of the Plan's electronic PHI of which the Plan Sponsor becomes aware; or (2) interference with system operations in the Plan Sponsor's information systems, involving the Plan's electronic PHI of which the Plan Sponsor becomes aware.

(v) The Plan Sponsor will make PHI available to the Plan or to the Member who is the subject of the information in accordance with 45 CFR§ 164.524.

(vi) The Plan Sponsor will make Members' PHI available for amendment, and will on notice amend Members' PHI, in accordance with 45 CFR § 164.526.

(vii) The Plan Sponsor will track disclosures it may make of Members' PHI that are accountable under 45 CFR § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(viii) The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of Members' PHI available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 CFR Part 164, Subpart E "Privacy of Individually Identifiable Health Information."

(ix) The Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Member PHI, in whatever form or medium, received from the Plan or any business associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Member who is the subject of the PHI, when the Members' PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Member PHI that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(d) *Adequate Separation Between the Plan Sponsor and the Plan.*

The following employees or classes of employees or other workforce members under the control of the Plan Sponsor may be given access to Members' PHI received from the Plan or a business associate servicing the Plan:

Members of the WELS VEBA Commission	*Workers of the WELS VEBA Benefit Plans Office*

This list includes every employee or class of employees or other workforce members under the control of the Plan Sponsor who may receive Members' PHI relating to payment under,

health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Members' PHI in breach or violation of or noncompliance with the provisions of this section. Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph (c)(iv)of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. The Plan Sponsor will ensure that access to PHI of the employees, or classes of employees identified above, is supported by reasonable and appropriate security measures, in accordance with 45 CFR §164.314(b)(2)(ii).

(e) *Safeguard Requirement.* Pursuant to 45 CFR §164.314(b)(2)(i), the Plan Sponsor will implement administrative, physical, and technical safeguards to reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

Coordination of Benefits

The Coordination of Benefits section is intended to determine which plan provides benefits when there are two or more plans providing coverage to an individual.

Definitions

For purposes of this Coordination of Benefits section, "plan" means any plan providing medical or dental benefits or services by a: (a) group, blanket, or franchise insurance coverage; (b) group practice, and other group prepayment coverage; (c) any coverage under labor-management trusted plans, union welfare plans, employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs such as, but not limited to, Medicare, and any coverage required or provided by any Statute; (e) individual automobile "no-fault" and traditional auto insurance; (f) individual or family insurance; (g) subscriber contracts; (h) individual or family coverage through health maintenance organizations (HMO); (i) limited service organizations or any other prepayment; (j) student accident insurance provided through or by an educational institution; (k) group practice or individual practice plan; and (l) this Plan.

The term "plan" is construed separately with respect to each plan, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such plan, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"Plan" is not any of the following:

1. Individual or family coverage, including insurance contracts, subscriber contracts, coverage through health maintenance organizations or other prepayment group practice and individual practice plans which are not group coverage.

2. Group or group-type hospital indemnity benefits of $100.00 per day or less.

3. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from" school basis.

"Allowable Expense" means any eligible charges within the Maximum Allowable Amount for Covered Services, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

If this Plan is the Secondary Plan and benefits are reduced under the Primary Plan because a Member does not comply with the Primary Plan's provisions, the Plan Administrator reserves the right to reduce the Maximum Allowable Amount under this Plan by the amount of such reduction. Examples of such provisions are those related to second surgical opinions, Precertification of admissions or services, and preferred Provider arrangements. Only benefit reductions based upon provisions similar to this one and which are contained in the Primary Plan may reduce the Maximum Allowable Amount for the Covered Service under this provision. This provision shall not be used by a Secondary Plan to refuse to pay benefits because an HMO member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to this Summary Plan Description, is not obligated to pay for providing those services.

Allowable Expense does not include any expenses incurred or claims made under the Prescription Drug program of this Plan.

"Claim Determination Period" means Benefit Period, except that if in any Benefit Period the person is not covered under the Plan for the full Benefit Period, the Claim Determination Period for that year will be that portion during which the person was covered under the Plan.

"Claim" means a request that benefits of a plan be provided or paid.

"Primary Plan" means a plan whose benefits are determined without regard to any other plan.

"Secondary Plan" means a plan that is not a Primary Plan according to the Order of Benefit Determination rules below, and the benefits under which are determined after those of another plan and may be reduced because of the other plan's benefits.

For purposes of this Coordination of Benefits section, this "Plan" means the WELS VEBA Group Health Care Plan.

Effect on Benefits

When a Member is covered under this Plan and another plan that together would pay more than the Allowable Expense with respect to a Covered Service, this Plan will pay benefits according to the Order of Benefits Determination rules and this paragraph. This Plan's benefit payments will not be affected if this Plan is the Primary Plan. If this Plan is Secondary Plan under the Order of Benefits Determination rules, however, this Plan will deduct the Primary Plan's payment from this Plan's Maximum Allowable Amount for the Covered Service and then apply the applicable deductibles, co-insurance and co-pay provisions under this Plan.

Order of Benefits Determination

The rules establishing the Order of Benefits Determination are:

1. If the other plan does not have Coordination of Benefits, that plan pays first.

2. The benefits of a plan which covers the person as an employee, member, or subscriber (other than as a dependent) are determined before the benefits of a plan which covers the person as a dependent.

3. **Birthday Rule:** the benefits of a plan which covers the person as a dependent are determined according to which parent's birthdate occurs first in a calendar year (day and month). If the birth dates of both parents are the same, the plan which has covered the person for the longer period of time will be determined first. If the other plan does not contain the birthday rule but has a rule which coordinates benefits based on gender and the plans do not agree on the Order of Benefits, the rule in the other plan will determine the Order of Benefits.

   If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the dependent are determined in this order:

   * when parents are separated or divorced and the parent with physical custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be the Primary Plan;

   * when parents are divorced and the parent with physical custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody are determined before the benefits of the plan which covers that child as a dependent of the stepparent. In addition, the benefits of a plan which covers that child as a dependent of the stepparent are determined before the benefits of a plan which covers that child as a dependent of the parent without custody; and

   * notwithstanding the provisions of the above, if there is a court decree which should otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility are determined before the benefits of any other plan which covers the child as a dependent child.

4. When rules 1., 2., and 3. do not establish an Order of Benefits Determination, the benefits of a plan which covers the person as a laid-off or retired employee, or as a dependent of such person, are determined after the benefits of a plan which covers such person through his or her own present employment or through the present employment of another person.

5. When rules 1., 2., 3., and 4. do not establish an Order of Benefits Determination, the benefits of a plan which has covered the person for the longer period of time are determined before the benefits of a plan which has covered such person the shorter period of time.

Right To Necessary Information

This Plan may require or may need to disclose certain information in order to apply and coordinate these provisions with other plans. To secure the needed information, this Plan, without the Member's consent, will release to, or obtain from, any insurance company,

organization or person, information needed to implement this provision. The Member shall agree to furnish any information required to apply these provisions.

Coordination of Benefits With Medicare

In all cases, Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations. If the Member is eligible for Medicare Benefits, but not necessarily enrolled, the benefits under this Plan will be coordinated to the extent benefits would have been payable under Medicare, to the extent allowed by Federal Statutes and Regulations.

Facility of Payment

Payment made under any other plan which, according to these provisions, should have been made by this Plan, will be adjusted. This Plan may pay to the organization which made a payment the amount which is determined to be warranted. Any amount paid is deemed to be a benefit paid under this Plan.

Coordination with No-Fault Automobile Insurance – Michigan Residents Only

If a claim is made due to a motor vehicle accident and the Member is covered by a No-Fault insurance required by state law, (Michigan residents only) the benefits payable under this Plan shall be primary.

Worker's Compensation

The Plan is not issued in lieu of, nor does it affect any requirement of coverage under any act or law which provides benefits for any Injury or Illness occurring during, or arising from, the employee's course of employment.

Other Government Programs

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

Subrogation and Right of Reimbursement

These provisions apply when Plan benefits are paid as a result of injuries or Illness you sustained and you have a right to a Recovery or have received a Recovery. Benefits you receive under this Plan are conditioned upon the Plan's right to subrogation and reimbursement as set forth in this Section.

Subrogation

Anthem, on behalf of the Plan and the Plan Administrator, has the right to recover for the Plan payments made by the Plan on your behalf from any party responsible for compensating you for your Injuries or Illness, including, but not limited to, any person, liability insurer, worker's compensation provider, uninsured motorist insurer, underinsured motorist insurer, "no fault" insurer or automobile insurer. The following rules apply:

- Anthem, on behalf of the Plan, has the first priority to recover the full amount of benefits the Plan has paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.

- You and your legal representative must do whatever is necessary to enable Anthem, on behalf of the Plan, to exercise the Plan's rights and do nothing to prejudice them. By way of example and not limitation, you and your legal representative shall not make any settlement which precludes or attempts to preclude the Plan from recovering the benefits paid under the Plan.

- Anthem, on behalf of the Plan, has the right to take whatever legal action it sees fit against any party or entity to recover the benefits paid under the Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim still held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

The Plan is not responsible for any attorney fees, other expenses or costs without its prior written consent. The "common fund" doctrine shall not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan, paid on your behalf, the Plan shall have a right to be repaid from the Recovery that portion of the total Recovery which is due to the Plan as described below. The Plan shall have an equitable lien on the Recovery to enforce this payment obligation. The following provisions define and apply to your repayment obligation:

- You must reimburse the Plan to the extent of Plan benefits paid to you or on your behalf from any Recovery.

- Notwithstanding any allocation made in a settlement agreement or court order, the Plan shall have a right of reimbursement, in first priority, against any Recovery.

- You and your legal representative and/or guardian must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or

    2. You fail to cooperate.

- In the event that you fail to disclose to Anthem and/or the Plan Administrator the amount of

your Recovery, the Plan shall be entitled to deduct the amount of its lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount it has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full-billed amount and the Plan would not have any obligation to pay the Provider.

The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Anthem promptly of how, when and where an accident or incident resulting in personal Injury or Illness to you occurred and all information regarding the parties involved.

- You must cooperate with Anthem, on behalf of the Plan Administrator, in the investigation, settlement and protection of the Plan's rights.

- You must not do anything to prejudice the rights of the Plan.

- You must send Anthem, on behalf of the Plan Administrator, copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or Illness to you.

- You must promptly notify Anthem, on behalf of the Plan Administrator, if you retain an attorney or if a lawsuit is filed on your behalf.

Failure to provide the cooperation set forth above, or any action by you or your legal representative resulting in prejudice to the Plan's rights will be a material breach of this Plan. The Plan Administrator has discretion to terminate your coverage prospectively based on such breach.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The Plan shall have an equitable lien by contract on any amount paid in error (including, without limitation, any overpayment) whether paid to, or held by, a Provider, Member, or any other person until the Plan recovers such amount.

Relationship of Parties (Plan Administrator-Member-Anthem)

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

Anthem Insurance Companies, Inc. Note

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges

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

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Plan Administrator at its principal place of business; to you at the Covered Worker's address as it appears on the records or in care of the Plan Administrator.

Member Agreement

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

Conformity with Law

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

Clerical Error

Clerical error on the part of the Plan Administrator or Anthem will not invalidate or extend coverage otherwise in force, nor continue coverage otherwise terminated. Upon the discovery of a clerical error, an equitable adjustment may be made as determined by Anthem or the Plan Administrator. The Member agrees to reimburse the Plan for any payment made to or for the Member in error.

Policies and Procedures

Anthem, on behalf of the Plan Administrator, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Waiver

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

Plan Administrator's Sole Discretion

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

Creditable Coverage

The period of any pre-existing condition limitation under a plan that would otherwise apply to a Member is reduced by the number of days of Creditable Coverage such individual had as of the enrollment date subject to the following:

1. days of Creditable Coverage that occur before a significant break in coverage will not be counted toward satisfying any pre-existing condition limitation provision of the Plan;
2. the amount of Creditable Coverage is determined by counting all of the days the individual had Creditable Coverage from one or more sources, provided that any days in a waiting period for a plan or policy are not considered Creditable Coverage; and
3. any coverage that is "Excluded Coverage" shall not be included as Creditable Coverage.

Procedure for Certificates of Coverage

An individual who wishes to receive a Certificate of Coverage for periods under this Plan should contact Anthem, the Claims Administrator, using the customer service telephone number on the back of his or her Identification Card. Anthem will give you a certificate after you lose coverage (whether regular coverage or continuation coverage) under the Plan, and will make reasonable efforts to provide on the certificate the names of your dependents who were also covered.

Appeal Process for Determination of Creditable Coverage

A Member who wishes to appeal an adverse determination of his or her Creditable Coverage by the Plan may appeal the determination by following the procedures in the "Benefit Claim and Appeal Procedures" section of the Plan. In such instances, an appeal of an adverse determination of Creditable Coverage will be handled in the same manner as if the adverse determination had been a denial of a claim for benefits under the Plan.

Duplication of Benefits

If any eligible charge is described as covered under two or more provisions within this Plan, the Plan will provide benefits based on the greater benefit. Only one benefit will be provided per covered expense.

Financing and Administration

No insurance company, insurance service or other state licensed entity is responsible for the financing or administration of the Plan. Benefits under the Plan are not guaranteed by a policy of insurance.

Plan Document

This document, including all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto, constitutes the entire Plan and is also intended to satisfy the requirements of a Summary Plan Description, as specified in ERISA.

Medical Care Provided By The United States

The Plan will reimburse eligible charges for medical care rendered by the Veteran's Administration for a non-service related Illness or Injury. The Plan will also reimburse eligible charges for medical care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis.

New Drugs, Medical Tests, Devices and Procedures

The Plan does not distinguish between “new” drugs or pharmaceuticals, medical tests, devices and procedures and existing drugs or pharmaceuticals, medical tests, devices and procedures when determining whether the drugs or pharmaceuticals, medical tests, devices and procedures are covered. New and existing drugs or pharmaceuticals, medical tests, devices and procedures are covered as specified in the “Schedule of Benefits” or other medical services sections of the Plan, provided they are not excluded by any provision of the Plan.

Participant Contribution

A participant contribution is the amount a Worker or Member is required to pay in order to participate in the Plan. Contact your Employer for contribution requirements. Individuals who are participating in the Plan by virtue of having exercised their rights under the section of the Plan entitled "Continuation of Coverage" will receive a separate notice which will indicate the cost to participate in the Plan.

The VEBA Commission shall, with the advice of an actuary, establish the contribution amounts that must be paid to the Plan for Members. In connection with establishing contribution amounts, the VEBA Commission, subject to applicable law, may divide Members into different classes and may require different contribution amounts for each class. The VEBA Commission may change the classes and contribution amounts effective the beginning of any calendar quarter.

Physical Examination

The Plan at its expense shall have the right and opportunity to have the Member examined for evaluation and verification of an Illness or Injury as often as it may be required during the pending of a claim.

Plan Amendment or Termination

Although the Plan Sponsor expects and intends in good faith to continue the Plan for an indefinite period of time, it reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time. Such amendment or termination of the Plan shall be performed in writing and executed by an officer or other authorized individual of the Plan Sponsor. In addition to the Plan Sponsor, the Plan Administrator may amend or modify the Plan, in whole or in part, at any time. Such amendment of the Plan shall be in writing and executed by an officer or other

individual authorized by the Plan Administrator. No amendment shall cause or permit any portion of Trust assets to be diverted to purposes other than for the exclusive benefit of Members, or cause or permit any portion of Trust assets to revert to or become the property of any Sponsoring Organization.

By written resolution, the Synodical Council may terminate this Plan or authorize the Plan Administrator to terminate this Plan. If the Synodical Council terminates the Plan, the termination will become effective when the Plan Administrator receives written notice of the termination executed by the President and the Secretary of the Synod or on the date specified in the written notice. The termination notice must contain the statement that any assets remaining in the Trust shall be used for life, sickness, accident or other benefits within the meaning of section 501(c)(9) of the Code.

Plan Administration and Interpretation

The Plan Administrator administers the Plan. The Plan Administrator has retained the services of Anthem as Third Party Administrator. Anthem provides administrative claim payment services only and does not assume any financial risk or obligation with respect to claims. The Plan is a legal entity and legal service of process directed to the Plan may be filed with the Agent for Service of Legal Process identified in the ERISA Information section.

The Plan Administrator shall administer the Plan in accordance with its terms and shall discharge its duties with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. The Plan Administrator shall have all powers necessary to manage and control Plan operations and administration. The Plan Administrator shall have full and complete authority and control with respect to Plan operations and administration unless the Plan Administrator allocates and delegates such authority or control pursuant to the procedures stated in b) or c) below. Any decision of the Plan Administrator shall be made in its sole and absolute discretion and shall be final and binding on all Members, all Employers, Sponsoring Organizations, and all other persons or parties. By way of example and not by way of limitation, the Plan Administrator shall have the sole and absolute discretion and authority to:

a) To employ such accountants, counsel or other persons as it deems necessary or desirable in connection with Plan administration, and to pay the costs of such services and other administrative expenses from the Trust, unless paid by the Synod or an Employer;

b) To designate in writing persons other than the Plan Administrator to perform any of its powers and duties hereunder including, but not limited to, Plan fiduciary responsibilities (other than any responsibility to manage or control the Plan assets);

c) To allocate in writing any of its powers and duties hereunder, including but not limited to fiduciary responsibilities (other than any responsibility to manage or control the plan assets) to those persons who have been designated to perform Plan fiduciary responsibilities;

d) To construe and interpret the Plan;

e) To resolve all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, questions as to the eligibility or the right of any person to participate in or to receive any benefit from the Plan;

f) To adopt such by-laws, rules, regulations, forms and procedures from time to time as it deems advisable and appropriate in the proper administration of the Plan;

g) To adopt such forms and procedures from time to time as it deems advisable for the submission of enrollment applications and modifications of prior enrollment elections, which procedures may include electronic submission of such applications and modifications;

h) To receive from an Employer or from Members such information as shall be necessary for the proper administration of the Plan;

i) To receive from the trustee for the Plan, and review, reports of the financial condition and receipts and disbursements of the Trust;

j) To collect and receive all contributions payable to the Trust in accordance with the Plan, and to authorize benefit payments and charges from the Trust as provided by the Plan;

k) To terminate a Sponsoring Organization's participation in the Plan;

l) To insure benefits with an insurance company or companies and negotiate and enter into insurance contracts;

m) To prescribe procedures to be followed by any person in applying for Plan benefits and to designate the forms or documents, evidence and such other information as the Plan Administrator may reasonably deem necessary, desirable or convenient to support an application for such distribution; and

n) To apply consistently and uniformly its rules, regulations and determinations to all Members in similar circumstances.

Pursuant to subsections b) and c) above, the Plan Administrator has contracted with Anthem to process claims, maintain Plan data, and perform other Plan connected services.

The Plan Administrator may exclude from the Plan, other provisions notwithstanding, a Sponsoring Organization or Workers of any Sponsoring Organization who are foreign nationals or residents in a foreign country, if the inclusion of such Workers would affect the status of the Trust as an exempt trust under section 501 of the Code, or if the Plan Administrator determines that the Plan would not operate in the best interest of such Workers, or if the inclusion of such Workers would present excessively complicated or difficult problems in the administration and operation of the Plan.

Plan Is Not A Contract

The Plan shall not be deemed or constitute a contract between any Sponsoring Organization and any Worker or other person or to be a consideration for, or an inducement or condition of, the employment of any Worker. Nothing in the Plan shall be deemed to give any Worker the right to be retained in the service of an Employer, or to interfere with or abridge the right of, an Employer to discharge any Worker at any time.

Presumption of Receipt of Information

It shall be presumed that any information, notification or decision, provided by the Plan through the U.S. Mail, to a Member or Provider located in the United States is received by the Member or Provider within three (3) days of the date of mailing to the last known address of such

Member or Provider.

Rescission of Coverage

The Plan has the right to rescind coverage for which any Worker or Member performs an act, practice or omission that constitutes fraud, or if the Worker or Member's Dependent(s) make an intentional misrepresentation of material fact. If the Plan determines that retroactive revocation is necessary, the Plan will provide you with at least thirty (30) Days' notice before the retroactive revocation is effective. To rescind means to cancel or discontinue coverage retroactively. For example, the Plan could rescind a Worker's coverage if the Worker made an intentional material misrepresentation. A material misrepresentation is an untrue statement which leads the Plan to cover the Worker or a Member or cover a medical condition of the Worker or a Member when it would not have done so if it had known the truth. The Plan will refund all contributions paid for any coverage rescinded, however claims paid will be offset from this amount. In addition, the Plan reserves the right to recover from the Worker, Member or Provider of service the amount paid on claims incurred during the period for which coverage is rescinded.

Rights With Respect To Medicaid

Payment of benefits with respect to a Member under the Plan will be made in accordance with any assignment of rights made by, or on behalf of, such Member as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

In enrolling an individual as a Member in the Plan or in determining or making any payments for benefits of an individual as a Member, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account.

To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act for supplies, services or treatments for a Member in those situations where the Plan has a legal liability to make such payment, the Plan will make payment for such benefits in accordance with any State laws which provide that the State has acquired the rights of a Member for payment for such supplies, services or treatments.

Self-funding

All contributions to the Plan shall be contributed to a Trust under the Plan. Except as expressly provided in the Plan, no Member or any other person shall have any right to Trust assets. *Plan benefits are paid solely from and are limited to the assets of the Trust*.

Sponsoring Organization Obligations

Each Sponsoring Organization agrees to:

A. Notify the Plan Administrator immediately of the employment of new Workers;

B. Inform its Workers promptly of their eligibility for membership in the Plan;

C. Permit each of its Workers who desires to enroll as a Member to enroll and to enroll the

Worker's Dependents;

D. Comply with the billing requirements established by the Plan Administrator;

E. Notify the Plan Administrator immediately of a termination of Covered Worker's employment, the granting and renunciation of leaves of absences involving a Covered Worker, and other facts or events relevant in the operation of the Plan;

F. To retain any employment or factual information related to E. above until any issue under the Plan has been resolved; and.

G. To distribute promptly to Members enrolled through the Sponsoring Organization, any notice or other communication to Members provided by the Plan Administrator.

Protection Against Creditors

The Plan shall pay benefits to Members and Providers; no benefit payment under this Plan shall be subject to alienation, sale, transfer, assignment, or pledge to any other person or entity except as expressly provided herein.

VEBA Commission

The VEBA Commission shall not be liable for Plan administration and duties except as expressly stated in the Plan as amended from time to time or as otherwise provided under applicable law. The VEBA Commission shall not be liable for the insolvency of or any other act of any insurance company with which it may contract pursuant to the Plan. No statement or advice by or on behalf of the VEBA Commission concerning the status of the Plan or Trust, the consequences of participation, or any Plan benefit under any tax or other law, shall impose liability upon the VEBA Commission or the Plan in the event of a determination contrary to such statement or advice. Except as otherwise expressly required under ERISA, the VEBA Commission shall not be liable for any mistake of judgment or other action taken in good faith; nor shall the VEBA Commission be liable for any loss sustained by the Trust by reason of the purchase, retention, sale or exchange of any investment in good faith and in accordance with the Trust. The VEBA Commission shall be responsible solely for its own acts and omissions and shall have no liability for the acts and omissions of others.

The Synod shall determine whether indemnification of any member or former member of the VEBA Commission is appropriate on a case-by-case basis. The Synod, however, will not provide indemnification if such person shall be finally adjudicated to be liable for misconduct in the performance of his duties or to have breached any fiduciary duty for which personal liability is imposed and for which indemnification is contrary to public policy as set forth in any applicable statute or judicial decision.

To the extent permitted by applicable law, the VEBA Commission may authorize the purchase and maintenance of insurance against liability which may be asserted against its members. If such insurance is in effect, payment of indemnity may be made by the insurer without specific authorization by the Synod. Except as may be required by law, no bond or other security (concerning the faithful performance of duties) shall be required of any member of the VEBA Commission.

BENEFIT CLAIM AND APPEALS PROCEDURES

Anthem's customer service representatives are specially 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 amounts;
- specific claims or services you have received;
- doctors or Hospitals in the Network;
- referral processes or authorizations; and/or
- Provider directories.

A complaint procedure has been established to provide fair, reasonable, and timely review of complaints that you may have concerning the Plan. Anthem invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by medical Providers in Anthem's Networks.

The Complaint Procedure

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

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from Anthem of its procedures and contracts. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint. If your complaint involves issues of Covered Services, you may be asked to sign a medical records release form so Anthem can request medical records for its review.

Adverse Benefit Determination

If Anthem denies your request for Precertification of, your request for Predetermination of, or your claim for Plan coverage in whole or in part, Anthem will provide you with a written notice of Adverse Benefit Determination within the time frames specified in the Plan below. A notice of Adverse Benefit Determination will include the following information:

- Information sufficient to identify the claim involved and a statement describing the availability to you, upon request and free of charge, of the diagnosis code (and its corresponding meaning) and the treatment code (and its corresponding meaning);
- The specific reason or reasons for the Adverse Benefit Determination;
- The specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including how to initiate an appeal, and the time limits applicable to such procedures, including a statement

of your right to bring a civil action under ERISA section 502(a) if you appeal the Adverse Benefit Determination under the **Benefit Claim and Appeals Procedures** and the Adverse Benefit Determination is upheld on appeal;

- Information regarding any internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination and about your right to request a copy of it free of charge, along with a discussion of the Adverse Benefit Determination;

- If the Adverse Benefit Determination is based upon Medical Necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical basis for the determination, applying the terms of the Plan to your medical circumstances or a statement that such an explanation will be provided to you free of charge upon request;

- In the case of an Urgent claim, a description of the Plan's expedited review procedures applicable to such claims; and

- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman who may assist you.

The Appeals Procedure

As a Member of the Plan, you have the right to appeal an Adverse Benefit Determination. You or your authorized representative may also file an appeal to address concerns regarding confidentiality or privacy. Appeals should be filed with Anthem for review in accordance with the procedures set forth below. In any case, Anthem will comply with the claims and appeals procedures required pursuant to applicable Department of Labor Regulations, as amended from time to time.

If you intend to appeal an Adverse Benefit Determination with respect to your claim, you or your authorized representative must do so within 180 calendar days after receiving that Adverse Benefit Determination. You will have the opportunity to submit written comments, documents, records, and other information supporting your appeal. Anthem's review of your appeal will take into account all information you submit, regardless of whether it was submitted or considered in the initial Adverse Benefit Determination.

Appeals

An appeal is a request from you for Anthem to change a previously made Adverse Benefit Determination. An initial determination by Anthem can be appealed for further review by Anthem at two (2) subsequent levels known as "Level 1" and "Level 2" appeals. As described below, a Level 2 appeal is voluntary. You may submit a request for independent External Review within four (4) months of the notice that Anthem has upheld its previous Adverse Benefit Determination following your Level 1 appeal. Alternatively, if you choose to submit a Level 2 appeal and do so timely, you must submit your request for an independent External Review within four (4) months of the notice that Anthem has upheld its previous Adverse Benefit Determination following your Level 2 appeal. After the later of your Level 2 appeal or your External Review, you may also appeal the determinations made by Anthem or the reviewer to the Plan Administrator in a voluntary Level 3 appeal. Anthem will advise you of your rights to the next level of review if a denial is upheld after a Level 1 appeal or a Level 2 appeal. The Plan will continue to provide coverage to you pending the outcome of your internal appeal(s). Please note that your request for diagnosis and treatment code information following an Adverse Benefit Determination will not, in and of itself, be considered an appeal.

The Plan's appeals procedures below are designed to ensure the independence and impartiality of the individuals making decisions on your appeal. Neither Anthem nor the Synod will make decisions regarding hiring, compensation, termination, promotion or other similar matters based on the likelihood that the individual making a decision in your appeal will support the denial of benefits.

You have the right to authorize a representative (e.g. your Physician) to file an appeal on your behalf and to represent you in the appeal. If a representative is seeking an appeal on your behalf, Anthem must obtain a signed designation of representation form from you before Anthem can begin processing your appeal unless a Physician is requesting expedited review of a Level 1 appeal on your behalf. If that occurs, the Physician will be deemed to be your representative for the purpose of filing the expedited Level 1 appeal without receipt of a signed form.

Once an appeal has been filed as described below, Anthem (or, in the case of a Level 3 appeal, the Plan Administrator) will accept oral or written comments, documents or other information relating to your appeal from you, your authorized representative or your Provider by telephone, facsimile or other reasonable means. You are allowed to present evidence and testimony as part of the Plan's appeals process. In addition, you are entitled to review the claim file, and to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to your appeal. At each level of appeal, the Plan fiduciary will take into account all comments, documents, records and other information submitted by you relevant to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In connection with any level of appeal described below, Anthem or the Plan Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Anthem, the Plan or the Plan Administrator (or at the direction of the Plan or Anthem) in connection with your claim or your appeal. Any new or additional evidence will be provided to you as soon as possible and sufficiently in advance of the date on which a decision on appeal is required to be provided, as described below, so you have a reasonable opportunity to respond to the new or additional evidence before the required notice date. If Anthem or the Plan Administrator bases its review of an Adverse Benefit Determination on a new or additional rationale, Anthem or the Plan Administrator must provide you, free of charge, with the rationale. The rationale will be provided to you as soon as possible and sufficiently in advance of the of the date on which a decision on appeal is required to be provided, as described below, so you have a reasonable opportunity to respond to the new or additional rationale before the required notice date.

Once Anthem has completed its review of your appeal, you or your authorized representative will receive a written notification of the Plan's benefit determination on review within the timeframes described below. If the Adverse Benefit Determination is upheld, such notification will include the specific reason or reasons for upholding the Adverse Benefit Determination, the specific Plan provisions on which the determination is based, and other information included in a notice of Adverse Benefit Determination (as described above). In addition, you will be entitled to receive, upon request and free of charge, reasonable access to and copies of the following information and documents:

- All documents, records and other information relevant to your claim for benefits;
- Internal rules, guidelines, protocols, or other similar criterion, if any, that was relied upon in making or upholding the Adverse Benefit Determination;

- An explanation of the scientific or clinical judgment for the Adverse Benefit Determination, if the Adverse Benefit Determination was based on Medical Necessity or Experimental treatment or similar exclusion or limit.

The notification regarding an upheld Adverse Benefit Determination on appeal will also describe the Plan's voluntary appeal procedures, as described below, and your right to obtain more information about such voluntary appeal procedures.

Additional information may be available from your local U.S. Department of Labor Office.

Level 1 Appeals

Level 1 appeals are reviewed by a fiduciary who did not make the initial determination and who is not the subordinate of the initial reviewer. If your appeal concerns an Adverse Benefit Determination that is based, in whole or in part, on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/Investigational, or not Medically Necessary or appropriate, Anthem will consult with an independent health care professional. The independent health care professional will have appropriate training and experience in the field of medicine related to the medical judgment. The independent health care professional will not be the same person with whom Anthem consulted in the initial Adverse Benefit Determination or the subordinate of such person. If a clinical issue is involved, Anthem will use a clinical peer for this review unless your appeal concerns an Adverse Benefit Determination regarding a voluntary Pre-Service Claim or unless the Adverse Benefit Determination can be overturned based upon prescreening by a nurse or other qualified reviewer. A clinical peer is a physician or provider who has the same license as the Provider who will perform or has performed the service. No deference shall be afforded the initial Adverse Benefit Determination. Upon request, Anthem will identify the medical or vocational experts whose advice it obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

Anthem requires its members to submit requests for appeal in writing, except as noted under the Expedited Appeal procedures below. Written appeal requests, including a detailed description of the problem and all relevant information, should be sent to: Attention: National Appeals; Anthem Blue Cross and Blue Shield; P.O. Box 105568; Atlanta, GA 30348. To file an appeal for an adverse Precertification decision by phone, you may contact the phone number provided on the written notice of an Adverse Benefit Determination that you receive from Anthem.

If you are appealing an Adverse Benefit Determination regarding a Pre-Service Claim, Anthem will provide you with a written response indicating the Plan's decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 days of the date Anthem receives your Level 1 appeal request. If more information is needed to make a decision on your appeal Anthem 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 Level 1 appeals without the permission of the Member. Therefore, Anthem will make a decision based upon the available information if the additional information requested is not received.

If you are appealing a Post-Service Claim and sufficient information is available to decide the appeal, Anthem will resolve your Level 1 appeal within a reasonable period of time but not later than 60 days from receipt of the Level 1 appeal request. If more information is needed to make a decision on your appeal, Anthem shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 60 days of the Level 1 appeal request, Anthem shall conduct its review based upon the available information.

Level 2 Appeals--Voluntary

If you are dissatisfied with the Level 1 appeal decision, you may request a Level 2 appeal within 60 days of the denial of the Level 1 appeal. A Level 2 appeal may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. At Level 2, the appeal is reviewed by individuals who did not make the initial Adverse Benefit Determination or the Level 1 determination and who are not the subordinates of the initial reviewer or the Level 1 reviewer. No deference shall be afforded the initial Adverse Benefit Determination. Upon request, Anthem will identify the medical or vocational experts whose advice it obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination. You have a right to personal appearance before the Level 2 appeals panel.

Your Level 2 appeal concerning an Adverse Benefit Determination regarding a Pre-Service Claim will be resolved by the panel no later than 30 days from the date your Level 2 appeal request was received by Anthem. Your Level 2 appeal concerning an Adverse Benefit Determination regarding a Post-Service Claim will be resolved by the panel no later than 60 days from the date your Level 2 appeal request was received by Anthem.

You are not required to pursue a Level 2 appeal. See the section below titled "Voluntary Appeals Not Required."

Expedited Reviews

For Pre-Service Claims involving Urgent Review or Concurrent Review, you may obtain an expedited appeal. You or your authorized representative may request such appeal orally or in writing. All necessary information, including the decision on appeal, can be sent between Anthem and you by telephone, facsimile or other similar method. To file an appeal for a claim involving Urgent Review or Concurrent Review, you or your authorized representative must contact Anthem at the number shown on your Identification Card and provide at least the following information:

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

Anthem will complete expedited review of a Level 1 appeal as soon as possible taking into account the medical urgency of the situation but not later than seventy-two (72) hours after Anthem receives the Level 1 appeal request and will communicate the Plan's decision by telephone to your attending Physician or the ordering Provider. Anthem will also provide written notice of the Plan's determination to you, your attending Physician, or ordering Provider, and the facility rendering the service.

Anthem will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and panel administration permits. The Plan's decision will be communicated by telephone to your attending Physician or the ordering Provider. Anthem will also provide written notice of the Plan's determination to you, your attending Physician, or ordering Provider,

and to the facility rendering the service. The Plan Administrator will complete expedited review of a Level 3 appeal as expeditiously as the medical condition requires and panel administration permits. The Plan's decision will be communicated by telephone to your attending Physician or the ordering Provider. The Plan Administrator will also provide written notice of the Plan's determination to you, your attending Physician, or ordering Provider, and to the facility rendering the service.

External Reviews

If you are dissatisfied with the Plan's Level 1 and, if applicable, Level 2 appeal decision and the previous Adverse Benefit Determination involving medical judgment or a rescission of coverage, an independent "External Review" may be available pursuant to federal law. An Adverse Benefit Determination involving medical judgment includes, but is not limited to, a determination based on the Plan's or Anthem's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or determination that a treatment is experimental or investigational. The Plan's voluntary Level 2 and Level 3 appeals procedures need not be exhausted prior to submitting your request for External Review. You must submit your request for External Review within four (4) months of the notice that Anthem has upheld its previous Adverse Benefit Determination following your Level 1 appeal. Alternatively, if you choose to submit a Level 2 appeal and do so timely, you must submit your request for an independent External Review within four (4) months of the notice that Anthem has upheld its previous Adverse Benefit Determination following your Level 2 appeal.

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

You may proceed with an *expedited* External Review at the time you receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited Level 1 or Level 2 appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited Level 1 or Level 2 appeal; or

- An Adverse Benefit Determination that is upheld after a Level 1 or Level 2 appeal, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the upheld Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you have received Emergency Care, but have not been discharged from a Provider.

Such *expedited* External Review is available without filing a Level 1 or Level 2 appeal or while simultaneously pursuing an expedited Level 1 or Level 2 appeal. You or your authorized representative may request an *expedited* External Review orally or in writing. All necessary information, including Anthem's decision, can be sent between the Anthem and you by telephone, facsimile or other similar method. To proceed with an *expedited* External Review, you or your authorized representative must contact Anthem at the number shown on your Identification Card and provide at least the following information:

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

All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to Attention: National Appeals; Anthem Blue Cross and Blue Shield; P.O. Box 105568; Atlanta, GA 30348.

External Review is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state or federal laws.

You are not required to pursue an External Review. See the section below titled "Voluntary Appeals Not Required."

If you would like a copy of the Plan's External Review procedures, please contact the Plan Administrator.

Level 3 Appeals—Voluntary

If you receive an Adverse Benefit Determination following your Level 2 appeal or, if applicable, following your External Review with respect to a claim, you may appeal the Adverse Benefit Determination to the Plan Administrator. This review will:

1. Not afford deference to earlier Adverse Benefit Determinations and provide that the review will be conducted by the Plan Administrator, which did not make the Adverse Benefit Determination that is the subject of the appeal;

2. Provide that, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary or appropriate, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

3. Identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and,

4. Provide that the health care professional who provides consulting services will be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination nor the subordinate of any such individual.

Level 3 appeals concerning Adverse Benefit Determinations regarding Pre-Service Claims will be resolved no later than 30 days from the date your Level 3 appeal request was received by the

Plan Administrator. All other Level 3 appeals will be resolved no later than 60 business days from the date your Level 3 appeal request was received by the Plan Administrator.

You are not required to pursue a Level 3 appeal. See the section below titled "Voluntary Appeals Not Required."

Appeals Filing Time Limit

You are encouraged to file Level 1 appeals on a timely basis. If you intend to appeal an Adverse Benefit Determination with respect to your claim, you must do so within 180 days after receiving that Adverse Benefit Determination. Except as noted in the previous sentence, Anthem will not review a Level 1 appeal if it is received after the end of the calendar year plus 12 months since the incident leading to the Member's appeal. Level 2 appeals must be filed within 60 days of receipt of notice of the Level 1 appeal determination. Level 3 appeals must be filed within 60 days following the later of your receipt of the Level 2 appeal determination or, if applicable, your receipt of the External Review determination. An External Review must be filed within four (4) months of the notice that Anthem has upheld its previous Adverse Benefit Determination following your Level 1 appeal. Alternatively, if you choose to submit a Level 2 appeal and do so timely, a Request for External Review must be filed within four (4) months of the notice that Anthem has upheld its previous Adverse Benefit Determination following your Level 2 appeal.

Voluntary Appeals Not Required

You must file a Level 1 appeal prior to bringing a civil action under 29 U.S.C. § 1132(a). The Level 2 appeal, External Review (if available), and Level 3 appeal are voluntary levels of review and need not be exhausted prior to filing suit. Thus, the Plan waives any right to assert that you failed to exhaust administrative remedies if you elect not to undergo a voluntary level of review. You will not be required to pay any fees or costs as part of a voluntary level of review. Any statute of limitation or other defense based upon timeliness will be temporarily suspended while a timely filed Level 2 appeal, request for External Review (if available), or Level 3 appeal is pending. You will be notified of your right to file for a voluntary level of review if the Plan's response to your current appeal level (i.e., Level 1 or Level 2 appeal) is adverse. Upon your request, Anthem will also provide you with detailed information concerning Level 2 appeals, External Reviews (if available), and Level 3 appeals, including how Level 2 panelists are selected, the applicable rules, your right to representation, and the circumstances, if any, that may affect the impartiality of the panelists for voluntary review. Your decision whether or not to submit a benefit dispute to a voluntary level of review will have no effect on your rights to any other benefits under the Plan.

Requirement to File an Appeal before Filing a Lawsuit

No lawsuit or legal action of any kind related to an Adverse Benefit Determination may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. However, if Anthem fails to strictly adhere to all of the claims and appeals processes under this section, you may be deemed to have exhausted the Plan's internal claims and appeals process pursuant to Department of Labor Regulation § 2590.715-2719(b)(2)(ii)(F), and you may file a lawsuit or take other legal action. If your appeal as described above results in an Adverse Benefit Determination, you have a right to bring a civil action under Section 502(a) of ERISA.

ERISA INFORMATION AND STATEMENT OF ERISA RIGHTS

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

ERISA INFORMATION

Plan Name:	WELS VEBA Group Health Care Plan This document describes the High Deductible Plan Option under the WELS VEBA Group Health Care Plan
Plan Sponsor:	Wisconsin Evangelical Lutheran Synod
Type of Plan:	Welfare plan designed to provide medical and prescription drug benefits
Type of Administration:	Plan is administered on a contract administration basis. The TPA provides administration services to plan
Plan Administrator and Named Fiduciary:	WELS VEBA Commission c/o Wisconsin Evangelical Lutheran Synod Benefit Plans Office N16W23377 Stone Ridge Dr Waukesha, Wisconsin 53188 (414) 256-3299
Employer Identification:	39-1522925
Plan Number:	501
Agent for Services of Legal Process:	WELS VEBA Commission c/o WELS Benefit Plans Office, N16W23377 Stone Ridge Dr, Waukesha, Wisconsin 53188, (414) 256-3299
Trustee:	BMO Harris Bank, N.A. 1000 North Water Street Milwaukee, WI 53202
Funding:	Synod, Sponsoring organization and member contributions are held in trust established under Section 501 (c) (9) of the code.
End of Plan Year:	12/31
Name of Claims Administrator:	Anthem Blue Cross and Blue Shield P. O. Box 105187 Atlanta, GA 30348

STATEMENT OF ERISA RIGHTS

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

Receive Information About The Plan and Benefits

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

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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