MEDICAL BENEFIT BOOKLET

For the

Aflac Medical Benefit Program

Administered By

Anthem BlueCross BlueShield

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 Member Services at the number on your Identification Card.

Effective 1/1/2020

This Benefit Booklet provides you with a description of the medical benefits you may receive while you are enrolled under the PPO Plan Medical Benefit Option which is offered under the Aflac Employee Health and Welfare Benefits Plan (the "Plan") sponsored by Aflac Incorporated (the "Employer"). You should read this booklet carefully and keep it handy for easy reference. If you have any questions about the benefits as presented in this benefit booklet, please contact the Aflac Benefits Department at 706-317-0770, go to myAflac.com > Employee Services > Benefits or contact Member Services by calling the toll-free number on your identification card.

The Plan provides the benefits described in this Benefit Booklet only for covered Employees, Retirees and their covered Dependents. The medical benefits described in this Benefit Booklet are subject to the limitations, exclusions, Copayments, Deductible and Coinsurance requirements specified in this Benefit Booklet. This Benefit Booklet replaces any prior Benefit Booklet you previously received. The medical benefits provided by the Plan are governed solely by the terms of this Benefit Booklet and the formal plan document for the Plan. The Plan's terms cannot be modified by any oral representation.

Anthem Blue Cross and Blue Shield, or "Anthem," has been designated by your Employer to provide third party administrative services for the Plan, such as claims processing, care management, and other services, and to arrange for a network of health care providers whose services are covered by the Plan. Anthem is referred to throughout this Benefit Booklet as the "Claims Administrator."

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or are funded by your contributions and contributions from your Employer. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Georgia. Although Anthem is the Claims Administrator and is licensed in Georgia, you will have access to providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

GA ADVANTAGE NETWORK– This is a Preferred Provider Organization (PPO) Plan for all Members except residents of Georgia; Members residing in Georgia are part of a Point of Service (POS) Plan, and must use the appropriate POS Network Provider in their state to receive Network benefits. If You are a Member in a state outside of Georgia that participates in an Advantage Network arrangement, please call the Member Services number on Your Identification Card to locate participating Providers.

Verification of Benefits

Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Member Services with a benefits inquiry or verification of benefits during normal business hours (7:00 a.m. to 9:00 p.m. eastern time). **Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment.** CALL THE MEMBER SERVICES NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Pre-certification rules.

How to Obtain Language Assistance

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

Claims and Appeals.

Please see the **"Claims Payment"** and **"Your Right to Appeal"** portions of this Benefits Booklet for important information about how to make a claim for benefits and the time limits for submitting a benefit claim or appealing a denied claim, and the section entitled "**Deadline for Filing a Lawsuit**" for important information about the applicable deadlines for filing a lawsuit.

AFLAC PPO PLAN

SCHEDULE OF BENEFITS – PPO PLAN

The Maximum Allowed Amount is the amount the Plan will reimburse for services and supplies which meet the definition of Covered Services, as long as such services and supplies are not excluded under the Plan; are Medically Necessary; and are provided in accordance with the terms of the Plan. See the Definitions and Claims Payment sections for more information.

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

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

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

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

Claims and Appeals. Please see the **"Claims Payment"** and **"Your Right to Appeal"** portions of this Benefits Booklet for important information about how to make a claim for benefits and the time limits for submitting a benefit claim or appealing a denied claim, and the section entitled "**Deadline for Filing a Lawsuit**" for important information about the applicable deadlines for filing a lawsuit.

AFLAC PPO PLAN

	Network	Out-of-Network
Calendar Year Deductible • Individual • Family – Employee/Retiree and all other covered Dependents combined	 $600 $1,200	 $1,200 $2,400
Out-of-Pocket Maximum • Individual • Family – Employee/Retiree and all other covered Dependents combined	 $3,000 $6,000	 $6,000 $9,000
Copayment Amounts • Hospital Copayment Amounts ➢ Emergency and Non-Emergency Room Services ➢ Urgent Care • Professional Copayment Amounts ➢ Urgent Care ➢ Non-Specialist / Specialist Physician	 $200 $35 $35 $25 / $35	 $200 N/A N/A N/A

Explanation of Calendar Year Deductible, Out-of-Pocket Maximum and Copayment Amounts

Calendar Year Deductible – The family amount can be satisfied by any combination of family members. In addition, an individual will not be required to satisfy more than the Plan's individual deductible amount. Instead, the individual's after-deductible benefits will begin to be paid as soon as he or she has met the individual deductible, even if the family deductible amount has not yet been met. Once the family deductible is met, the Plan will pay after-deductible benefits for every covered individual, regardless of whether each family member has reached the individual deductible. Amounts satisfied toward the Network calendar year Deductible will be applied toward the Out-of-Network calendar year Deductible. However, amounts satisfied toward the Out-of-Network calendar year Deductible will NOT be applied toward the Network calendar year Deductible. A separate deductible applies to prescription drug expenses, as described in the enrollment materials and the benefit summary provided for the prescription drug benefit program.

Out-of-Pocket Maximum – The family amount can be satisfied by any combination of family members. In addition, an individual will not be required to satisfy more than the Plan's individual out-of-pocket maximum amount. Instead, once an individual with family coverage meets the Plan's individual out-of-pocket maximum, the Plan will pay 100% of all Covered Services for that individual, even if the family out-of-pocket maximum has not been met. Once the family out-of-pocket maximum is reached, the Plan will pay 100% of all Covered Services for every covered individual, regardless of whether each family member has reached the individual maximum. Amounts satisfied toward the Network Out-of-Pocket Maximum will be applied toward the Out-of-Network Out-of-Pocket Maximum. However, amounts satisfied toward the Out-of-Network Out-of-Pocket Maximum will be NOT be applied toward the Network Out-of-Pocket Maximum. The Out-of-Pocket Maximum does NOT include pre-certification penalties, charges in excess of the Maximum Allowed Amount, non-Covered Services, pharmacy claims and services deemed not Medically Necessary by the Claims Administrator. Prescription drug expenses apply to a separate out-of-pocket limit, as described in the enrollment materials and the benefit summary provided for the prescription drug benefit program.

Copayment Amounts – Non-specialist Physicians include Family Practice, General Practitioner, Pediatrician, Internal Medicine, Mental Health Physician and Physician Assistant. All other professional providers are considered Specialist Physicians and the applicable Copayment will apply. If you have an office visit with your Primary Care Physician or Specialty Care Physician at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under the "Outpatient Hospital / Facility Services" section below in this Schedule. Please refer to that section for details on the cost shares

(e.g., Deductibles, Copayments, Coinsurance) that will apply

AFLAC PPO PLAN

Schedule of Benefits	Network	Out-of-Network
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified) • Plan Pays • You Pay	 80% 20%	 70% 30%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, you are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		
All Covered Services are subject to the Deductible unless otherwise specified in this booklet.		
Applied Behavioral Analysis		
Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	Covered at the benefit level of services billed.	70%
Allergy Care		
• Office Visit Copayment / Coinsurance – non-specialist / specialist Physician • Testing and Treatment **Note:** Copayment is NOT applied to testing and treatment. Network services are NOT subject to Deductible. For Out-of-Network, you must first satisfy the Out-of-Network Deductible and then payment is at 70%	$25 / $35 100%	70% 70%
Behavioral Health / Substance Abuse Care – Requires Pre-certification for certain services • Office Visit • Outpatient • Intensive Outpatient • Inpatient (Includes Residential Treatment Center and Partial Hospitalization) • Online Visits (LiveHealth Online Psychology) • Methadone Clinic Services	 $25 $25 80% 80% $25 80%	 70% 70% 70% 70% 70% 70%
Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.		
Birth Control		
• Covered Services for birth control as well as medical conditions – IUDs, Injections for Depo-Provera and diaphragm fittings	100%	70%

AFLAC PPO PLAN

Schedule of Benefits	Network	Out-of-Network
Dental & Oral Surgery / TMJ Services		
• Dental services related to an Accidental Injury to sound, natural teeth ➢ limited to repair of soft tissue and related x-rays	80%	70%
• Oral Surgery	Covered at Surgery Level	Covered at Surgery Level
• TMJ – surgical and non-surgical medical treatment – excludes appliances	Covered at the benefit level of services billed.	Covered at the benefit level of services billed.
Diagnostic Physician's Services		
• Diagnostic services Copayment / Coinsurance by a non-specialist / specialist Physician – office or home visit ➢ Includes consultations and second surgical opinions outpatient setting or office	$25 / $35	70%
• Diagnostic x-ray and lab – office, outpatient or independent lab	100%	70%
Note: Network services are NOT subject to Deductible. For Out-of-Network, you must first satisfy the Out-of-Network Deductible and then payment is at 70%		
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Care, Urgent Care and Ambulance Services		
• Emergency Room for a Medical Emergency		
➢ Hospital Copayment (waived if admitted)	$200	$200
➢ Coinsurance after Copayment	100%	Paid at Network Level
➢ Emergency Room Physician – not subject to Deductible	100%	Paid at Network Level
• Non-Emergency Use of Emergency Room		
➢ Hospital Copayment	$200	$200
➢ Coinsurance after Copayment	80%	70%
➢ Emergency Room Physician	80%	70%
• Urgent Care		
➢ Office / outpatient Copayment	$35	N/A
➢ Coinsurance after Copayment – Deductible waived for Network services	100%	70%
• Ambulance Services (when Medically Necessary) Land / Air	80%	Paid at Network Level
Note: **Care received Out-of-Network for a Medical Emergency will be provided at the Network level of benefits if the following conditions apply:** A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out–of-Network Provider is used, however, you are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		

AFLAC PPO PLAN

Schedule of Benefits	Network	Out-of-Network
Eye Care / Hearing Care (Non-routine)		
• Office Visit Copayment / Coinsurance – non-specialist / specialist Physician – treatment of medical conditions or Injury to the eye / ear • Coinsurance after Copayment • Hearing aid services **Note:** Routine eye screenings may be covered under Preventive Services.	$25 / $35 100% 80%	N/A 70% Paid at Network Level
Gene Therapy Services Precertification required	80%	70%
Home Health Care Services – Pre-certification Required		
• Home Health Care Services – includes home infusion therapy and private duty nursing	80%	Paid at Network Level
• Maximum visits per calendar year – Network and Out-of-Network combined	100	
Hospice Care Services		
• Hospice Care Services	80%	Paid at Network Level
Hospital Inpatient Services		
Inpatient Facility Services – Pre-certification required ➢ Room and board (Semi-private or ICU/CCU) ➢ Hospital services and supplies (x-ray, lab, anesthesia, surgery, maternity, Inpatient Physical Therapy, etc.) ➢ Medical Rehabilitation • Inpatient Professional Services ➢ Inpatient Medical Care ➢ Well Newborn Care – Deductible applied to mother's claim only ➢ Surgeon ➢ Assistant Surgeon ➢ Radiologist ➢ Pathologist ➢ Anesthesiologist	80% 80% 80% 80% 80% 80% 80% 80% 80% 80%	70% 70% 70% 70% 70% 70% 70%* 70%** 70%** Paid at Network Level

*Out-of-Network assistant surgeon services performed in conjunction with a Network surgeon are covered at the Network level.
**Out-of-Network radiologist and pathologist charges are always paid at the Network level when performed in a Network facility.

AFLAC PPO PLAN

Schedule of Benefits	Network	Out-of-Network
Maternity Care		
• Initial office visit Copayment – non-specialist / specialist Physician ➢ Coinsurance after Copayment (initial visit) • All other Physician's services for ➢ Pregnancy, childbirth, pregnancy-related conditions and abortions ➢ Newborn nursery services (well baby care) ➢ Circumcision	$25 / $35 100% 80%	N/A 70% 70%
Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified.		
Medical Equipment and Supplies		
• Durable Medical Equipment – Purchase and Rental ➢ Glasses or contact lenses after cataract surgery ➢ Medical Supplies ➢ Diabetic supplies – excludes supplies covered under drug card ➢ Orthotics (subject to Medical Necessity) / Prosthetic appliances (external) **Note**: Orthotics must be pre-certified and prosthetics that exceed $2,500 must also be pre-certified. **Note:** Wigs and toupees are NOT covered.	80%	Paid at Network Level
Nutritional Counseling		
• Nutritional counseling for diabetes diagnosis only • Nutritional counseling for eating disorders	80% 80%	70% 70%
Occupational, Physical and Speech Therapy		
• Non-Physicians (e.g. audiologists) are covered. • Copayment per visit – non-specialist / specialist Physician	$25 / $35	70%
• Maximum visits per calendar year – Network / Out-of-Network and Institutional / Professional combined	30 Visits Per Therapy	

AFLAC PPO PLAN

Schedule of Benefits	Network	Out-of-Network
Outpatient Hospital / Facility Services		
• Outpatient Copayment for MRIs, CT scans, MRAs and PET scans	$50	N/A
➢ Coinsurance after Copayment	100%	70%
• Pre-surgical / pre-admission testing	80%	70%
• Ambulatory and minor surgery (institutional)	80%	70%
• Outpatient surgery professional services		
➢ Surgeon	80%	70%
➢ Assistant Surgeon	80%	70%
➢ Anesthesiologist	80%	Paid at Network Level
Note: Out-of-Network assistant surgeon services performed in conjunction with a Network surgeon are covered at the Network level.		
Physician Services (Home and Office Visits)		
• Copayment per visit – non-specialist / specialist Physician	$25 / $35	N/A
• Office surgery	100%	70%
• Injections in Physician's office	100%	70%
• Travel immunizations	100%	70%
Note: Out-of-Network assistant surgeon services performed in conjunction with a Network surgeon are covered at the Network level.		
Preventive Services (Network Services Not Subject to Deductible)		
• Preventive Services for Children Under Age19	100%	70%
➢ Non-specialist / specialist Physician		
► Age appropriate periodic health assessments		
► Developmental assessment of the child		
➢ Age appropriate immunizations (includes travel)	100%	70%
➢ Preventive x-ray and laboratory testing – office or independent lab	100%	70%
► Includes routine hearing and vision screenings		

AFLAC PPO PLAN

Schedule of Benefits	Network	Out-of-Network
Preventive Services (Network Services Not Subject to Deductible)		
• Preventive Services for Adults Age 19 and Above ➢ Non-specialist / specialist Physician ► Periodic health assessments ➢ Immunizations (includes travel), flu injections ➢ Preventive x-ray and laboratory testing – office or independent lab ➢ Routine cholesterol screening ➢ Routine colon cancer screening ► Routine fecal occult blood test ► Routine barium enema ► Routine sigmoidoscopy ➢ Routine colonoscopy (Facility and anesthesia services billed for routine colonoscopy covered at same benefit as colonoscopy.) ➢ Preventive x-ray and laboratory testing – office or independent lab ► Includes routine hearing screenings	 100% 100% 100% 100% 100% 100% 100%	 70% 70% 70% 70% 70% 70% 70%
• Specific Preventive services for Women ➢ Gynecological exam – non-specialist / specialist Physician ➢ Pap Smear ➢ Routine mammography – one per calendar year	 100% 100% 100%	 70% 70% 70%
• Specific Preventive services for Men ➢ Non-specialist / specialist Physician ➢ Prostate Cancer Screening (PSA)	 100% 100%	 70% 70%
• Hearing Exams	100%	100%
• Vision care – routine exam, prescription lenses, frames, contact lenses and LASIK surgery	100%	100%
• Maximum benefit – every 24 months – combined Network and Out-of-Network	$200	
Note: Preventive Services are defined as any claim submitted with a “well” diagnosis.		
Skilled Nursing Facility (Pre-certification Required)		
• Skilled Nursing Facility Services	80%	Paid at Network Level
• Maximum days per calendar year – combined Network and Out-of-Network	60	

AFLAC PPO PLAN

Schedule of Benefits	Network	Out-of-Network
Sterilization Services (Pre-certification required for Inpatient procedures.)		
• Tubal ligation - Sterilizations for women will be covered under the "Preventive Care" benefit.	100%	70%
• Vasectomy **Note:** Reversals are NOT covered.	80%	70%
Therapy Services (Outpatient)		
• Occupational Therapy / Physical Therapy / Speech Therapy and Acupuncture ➢ Copayment per visit – non-specialist / specialist Physician	$25 / $35	70%
➢ Maximum visits per calendar year for all therapies – combined Network / Out-of-Network and combined Institutional / Professional	30 visits per therapy	
• Chiropractic Care ➢ Copayment / Coinsurance per visit	$35	70%
➢ Maximum visits per calendar year for all chiropractic services – combined Network and Out-of-Network **Note:** Network services not subject to Deductible.	13	
• Other covered outpatient therapy services ➢ Cardiac Rehabilitation ➢ Chemotherapy ➢ Hemodialysis ➢ Radiation Therapy ➢ Respiratory Therapy ➢ Blood	80%	70%
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		

AFLAC PPO PLAN

Transplant Schedule of Benefits	Centers of Excellence (COE) Provider	Network Transplant Provider	Out-of-Network Transplant Provider
• Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, including Medically Necessary preparatory myeloablative therapy. • **The Center of Excellence requirements do not apply to** cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **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 the Claim Administrator to determine which Hospitals are Network Transplant Providers. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.)			
• Institutional Services for Organ and Stem Cell / Bone Marrow Transplant – Pre-certification required	100%	80%	Not Covered
• Professional services for Organ and Stem Cell / Bone Marrow Transplant	100%	80%	Not Covered
• Transplant Donor Services – (including complications from the donor procedure for up to six weeks from the date of procurement)	100%	Not Covered	Not Covered
• Eligible Travel and Lodging ➢ $10,000 maximum per Transplant / $20,000 per Transplant ➢ $50 maximum per day for lodging (double occupancy) **Note:** Services performed at COE provider not subject to Deductible.	100%	Not Covered	Not Covered

TOTAL HEALTH AND WELLNESS SOLUTION

24/7 NurseLine
You may have emergencies or questions for nurses around the clock. 24/7 NurseLine provides you with accurate health information any time of the day or night through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number. You can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting and refer you to programs and tools appropriate to your condition.
- Bilingual RNs, language line and hearing impaired services.
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison-control and pediatric Members with needs identified as either emergent or urgent.
- Referrals to relevant community resources.

Sydney App
On the go, we're with You. Find an urgent care center. Share your Identification Card on your smartphone at the doctor's office. Check your claim status. With the Anthem Anywhere mobile app, you can find a doctor, access your mobile Health Record, view your Identification Card, check your claim status, and more – all from your smartphone or mobile device.

Standard Autism Spectrum Disorders (ASD) Program
The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a Member who has a diagnosis of ASD. Anthem provides specialized case management services for Members with autism spectrum disorders and their families. The Program also includes precertification and Medical Necessity reviews for Applied Behavior Analysis, a treatment modality targeting the symptoms of autism spectrum disorders.

For families touched by ASD, Anthem's Autism Spectrum Disorders Program provides support for the entire family, giving assistance wherever possible and making it easier for them to understand and utilize care, resulting in access to better outcomes and more effective use of benefits. The ASD Program has three main components:

- **Education**

Educates and engages the family on available community resources, helping to create a system of care around the Member.

Increases knowledge of the disorder, resources, and appropriate usage of benefits

- **Guidance**

Applied Behavior Analysis management, including clinical reviews by experienced licensed clinicians. Precertification delivers value, ensuring that the Member receives the right care, from the right Provider, at the right intensity.

Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning, and referrals.

Assure that parents and siblings have the best support to manage their own needs.

- **Coordination**

Enhanced Member experience and coordination of care.

Assistance in exploration of medical services that may help the Member, including referrals to medical case management.

Licensed Behavior Analysts and Program Managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic child.

ComplexCare

The ComplexCare program reaches out to you if you are at risk for frequent and high levels of medical care in order to offer support and assistance in managing your health care needs. ComplexCare empowers you for self-care of your condition(s), while encouraging positive health behavior changes through ongoing interventions. ComplexCare nurses will work with you and your Physician to offer:

- Personalized attention, goal planning, health and lifestyle coaching.
- Strategies to promote self-management skills and medication adherence.
- Resources to answer health-related questions for specific treatments.
- Access to other essential health care management programs.
- Coordination of care between multiple Providers and services.

The program helps you effectively manage your health to achieve improved health status and quality of life, as well as decreased use of acute medical services.

ConditionCare Programs

ConditionCare programs help maximize your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult).
- Diabetes (pediatric and adult).
- Heart failure (HF).
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).

You will receive:

- 24/7 phone access to a nurse coach who can answer your questions and give you up-to-date information about your condition.
- A health review and follow-up calls if you need them.
- Tips on prevention and lifestyle choices to help you improve your quality of life.

Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches supported by pharmacists, registered dietitians, social workers and medical directors. You will receive:

- 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions.
- *Your Pregnancy Week by Week*, a book to show you what changes you can expect for you and your baby over the next nine months.
- Useful tools to help You, Your Physician and Your Future Moms nurse coach track Your pregnancy and spot possible risks.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep you and your bank account healthier. Here's how it works: the Claims Administrator will review your incoming health claims to see if the Plan can save you any money. The Claims Administrator can check to see what medications you are taking and alert your Physician if the Claims Administrator spots a potential drug interaction. The Claims Administrator also keeps track of your

routine tests and checkups, reminding you to make these appointments by mailing you MyHealth Notes. MyHealth Notes summarize your recent claims. From time to time, the Claims Administrator will offer tips to save you money on Prescription Drugs and other health care supplies.

Quick Care Options
Quick Care Options helps to raise your awareness about appropriate alternatives to Hospital emergency rooms (ERs). When you need care right away, Retail Health Clinics and Urgent Care centers can offer appropriate care for less cost and leave the ER available for actual emergencies. Quick Care Options educates you on the availability of ER alternatives for non-urgent diagnoses and provides the Provider finder website to support searches for ER alternatives.

ELIGIBILITY

Employee Eligibility

You are eligible to participate in the Plan if you are classified by Aflac (i) as a full-time employee not covered under a collective bargaining agreement and you are regularly scheduled to work at least 30 hours per week or (ii) you are considered eligible under the Affordable Care Act ("ACA Eligible Employee"). This Benefit Booklet describes the benefits an Eligible Employee may receive under this Plan.

You are an "ACA Eligible Employee" if you:

- Worked an average of thirty (30) or more hours per week during the Applicable Measurement Period; or
- Are a newly hired employee and reasonably expected to work an average of thirty (30) or more hours per week based on the position for which you were hired and your manager's verification of your position.
- Note under the ACA, whether or not you elect coverage under this Plan for you and your eligible dependents, you and your eligible dependents will be ineligible for a subsidy in a marketplace exchange. If you received a subsidy in a marketplace exchange, you may be required to pay all or a portion of the subsidy back when you file your tax return

For ACA Eligible Employees, the "Applicable Measurement Period" is the period during which the Employer reviews your hours to determine whether you are eligible for coverage. The "Applicable Stability Period" is the twelve (12) months during which the Employer will offer Plan coverage to ACA Eligible Employees who averaged at least thirty (30) hours or more per week during the Applicable Measurement Period.

The Applicable Measurement Period and the Applicable Stability Period vary based on your date of hire. *For Example:*

If you are an ACA Eligible Employee and you were hired on or before October 4, 2018, the Applicable Measurement Period for the 2020 Plan Year runs from October 4, 2018-October 3, 2019 and the Applicable Stability Period runs from January 1, 2020 through December 31, 2020.

If you are an ACA Eligible Employee and you were hired after October 4, 2018, the Applicable Measurement Period for the 2020 Plan Year runs for 11 months and is based on your date of hire. For example, if you were hired on January 24, 2019, your Applicable Measurement Period would be from February 1, 2019, through December 31, 2019, and the Applicable Stability Period would begin no later than the first of the month following thirteen months after your hire date, March 1, 2020 – February 28, 2021.

During a Stability Period, the Employer will continue to offer you medical coverage even if you do not maintain full-time status.

If you fail to maintain full-time status during the Plan year and are not an ACA Eligible Employee, coverage will end. You may elect COBRA coverage. See the Coverage Continuation section for more information.

Coverage will also end once the Applicable Stability Period ends if you did not average thirty (30) or more hours per week during the Applicable Measurement Period and you are not otherwise a Full-Time Employee. You may elect COBRA coverage. See the Coverage Continuation section for more information.

Enrollment Requirements:

Full-Time Employees who are not ACA Eligible Employees, may enroll during the following times:

- On the first day of Employment;
- Within thirty-one (31) days following their hire date;
- During an Annual Election Period, usually held each autumn;
- Within thirty-one (31) days of a Qualified Status Change Event (as described below); or
- During a Special Enrollment Period:

- Within thirty-one (31) days of the birth, adoption, or placement for adoption of a Child: coverage will begin retroactive to the date of the birth, adoption, or placement for adoption, provided a written request is received within thirty-one (31) days of the event;
- Within thirty-one (31) days of marriage: coverage will begin the 1st day of the calendar month following receipt of the timely written request;
- Within thirty-one (31) days of loss of other employer sponsored group health coverage or health insurance coverage: coverage will begin the first day of the calendar month following receipt of the timely written request;
- Within sixty (60) days of a loss of coverage under Medicaid or a State child health plan or becoming eligible for a premium assistance subsidy through Medicaid or a State child health plan.

For more information on Special Enrollment Periods, please see the section titled "Special Enrollment Period" below.

An ACA Eligible Employee may enroll during the following times:

- During an Annual Election Period, if he or she worked 30 hours or more per week during the Applicable Measurement Period; or
- Within thirty-one days after your Applicable Measurement Period ends if you were hired on or after October 4, 2017.

An Employee eligible for the Plan does not include:

- an individual classified by the Employer as an independent contractor or temporary or seasonal employee (unless eligible as an ACA Eligible Employee) under the Employer's customary work classification practices (whether or not the individual is an employee or reclassified as an employee by the Internal Revenue Service, administrative agency or court of competent jurisdiction);
- employees covered under a collective bargaining agreement, unless the collective bargaining agreement expressly provides that coverage under the Plan is provided to employees in the bargaining unit and the agreement is currently in place.

Retiree Eligibility

You are eligible to participate in the retiree coverage under this Plan if you are classified by Aflac as an eligible Retiree of Aflac. You qualify as a Retiree under this Plan if you were an Employee who participated in the Plan at the time you elected early retirement from Aflac (i) after attaining age 55 with 15 or more years of active service with Aflac; or (ii) after attaining an age which, when added to the number of years of service with Aflac, equals 80. You must elect to continue your participation in this Plan within 60 days after the date of your early retirement. If you do not elect coverage at this date, you may not later enroll for retiree coverage.

Eligible Dependents

If the Employee or Retiree is covered by this Plan, the Employee/Retiree may enroll his or her Eligible Dependents. Covered Dependents are also called"Members" in this Benefit Booklet.

If the wrong birth date of a child is entered on an application, the child has no coverage for the period for which he or she is not eligible under the terms of the Plan. Any overpayments made for coverage for any child under these conditions will be refunded by the Employee.

Eligible Dependents include:

- The covered Employee's legal spouse, registered domestic partner, the biological children of employees, the biological children of registered domestic partners, and the stepchildren of employees; adopted children and children placed in an employee's home for adoption before reaching age 18; and children for whom an employee is appointed as legal guardian. Dependent children are eligible for coverage until age 26, even if eligible for coverage under another employer-sponsored plan. **Note:** Eligibility for a Retiree's legal spouse or registered domestic partner under the Retiree medical benefit program offered under the Plan ends once the spouse or domestic partner becomes eligible for (i) Medicare due to age or disability, or (ii) another employer's health plan.

- Children who are mentally or physically impaired and totally dependent on the Employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the impairment is required within 31 days of attainment of age 26. A certification form is available from the Employee Benefits Department and may be required periodically. You must notify the Employee Benefits Department if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

Any employee enrolling a new spouse, a new registered domestic partner, or any dependent children will need to provide to the Employee Benefits Department the following information before enrollment becomes effective: A marriage certificate or certificate of registration as a domestic partner, and the birth certificates of all children being added to the Plan.

You must notify the Employee Benefits Department before the date that is 31 days after any status change that would result in a dependent no longer being eligible for Plan participation (for example, your former Spouse in the event of a divorce). For COBRA Continuation Coverage purposes, however, you have 60 days to provide the Aflac Employee Benefits Department with notice of divorce or that a child is no longer an Eligible Dependent. Failure to inform the Plan that a dependent is no longer eligible for coverage is considered an intentional misrepresentation of material fact entitling the Plan to rescind the dependent's coverage. Coverage will end on the first date the dependent is no longer eligible for Plan participation, even if Aflac discovers the dependent is no longer eligible at a later date. The Plan has the right to recover from you any payments the Plan makes on behalf of an individual who is no longer an Eligible Dependent.

You may not participate in this Plan as both an Employee/Retiree and a Dependent, and your Dependents may not participate in this Plan as a Dependent of more than one Employee/Retiree.

Qualified Medical Child Support Order ("QMCSO")

The Plan Administrator will honor an order that is a "**Qualified Medical Child Support Order**" including a National Medical Support Notice, within the meaning of ERISA Section 609(a)(2)(A) ("**QMCSO**"). The Plan Administrator has established written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the Plan pursuant to a valid QMCSO. These procedures are available from the Plan Administrator upon written request at no charge. The Plan Administrator has full discretionary authority to determine whether a medical child support order is "qualified" within the meaning of ERISA Section 609(a)(2)(A), and reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency.

Initial Enrollment Period

As a newly Eligible Employee, you may participate in the Plan as long as you enroll by on-line at myAflac.com by following the procedures listed in Benefits Guide within thirty days of the day you become eligible ("**Initial Enrollment Period**").

If you enroll your Eligible Dependents, you will need to provide documentation to prove that your dependents meet the eligibility requirements. Failure to provide the documentation upon request could result in a loss of coverage for your dependents, as of the dependent's original eligibility date.

After you complete your on-line enrollment, your participation in the Plan will start on the first day following thirty days of employment. The benefit choices you make during your Initial Enrollment Period will remain in effect for the remainder of the Plan Year, unless you have a Special Enrollment Period or you experience a Qualified Status Change Event and you make new benefit elections.

If you do not enroll yourself (and your Eligible Dependents) in the Plan during your Initial Enrollment Period, you will not receive coverage, and you may not enroll until the next Annual Enrollment Period, Special Enrollment Period or until you experience a Qualified Status Change Event.

Annual Enrollment Period

Each year, Aflac establishes an Annual Enrollment Period, usually in the fall. During the Annual Enrollment Period, you can enroll for the first time or make new benefit choices for the upcoming Plan Year at MyAflac.com by following the procedures listed in the Benefits Guide. If you enroll your Eligible Dependents during the Annual Enrollment Period, you must provide documentation to prove that your dependents meet the eligibility requirements. Failure to provide the documentation upon request could result in a loss of coverage for your dependents, as of the dependent's original eligibility date.

Aflac may require an Active or Passive Annual Enrollment Period. Before the Annual Enrollment Period begins each year, Aflac will inform you whether the Annual Enrollment Period will be Active or Passive.

- ***Active Annual Enrollment Period***. If you do not enroll or make new benefit choices during an **Active Annual Enrollment Period**, your elections for the previous Plan Year will end. You must wait to enroll or to change your benefit choices until the next Annual Enrollment Period, Special Enrollment Period, or until you experience a Qualified Status Change Event.

- ***Passive Annual Enrollment Period***. If you previously enrolled in the Plan, but you do not change your existing elections during a **Passive Annual Enrollment Period**, your elections for the previous Plan Year and any new Benefit Contributions for those benefits will remain in effect during the upcoming Plan Year.

The benefit elections you make during the Annual Enrollment Period will take effect on January 1st and will remain in effect until December 31st. You may not change your benefit elections during this period, unless you have a Special Enrollment Period, or you experience a Qualified Status Change Event.

If you are eligible to participate in the Plan and the Annual Enrollment Period falls during a time when you are on a FMLA leave of absence, Aflac will contact you so that you may make your elections during the Annual Enrollment Period.

Special Enrollment Period

You and your Eligible Dependents may enroll in the Plan under the following circumstances:

- ***Individuals Losing Other Coverage***. If you declined coverage under the Plan when it was first available because of other health coverage, and that coverage is later lost on account of:

  - Exhaustion of COBRA Continuation Coverage,

  - Lost Eligibility for Other Coverage, or

  - Termination of employer contributions towards the other coverage,

  you and your Eligible Dependents may enroll in the Plan within 31 days of the date you lost that other coverage. Your enrollment will take effect on the first day of the calendar month following receipt of your request for enrollment. The change in your Benefit Contributions will begin on the first payroll period following your election change request.

Lost Eligibility
"**Lost Eligibility for Other Coverage**" means a loss of other health coverage as a result of your legal separation or divorce, a dependent's loss of dependent status, death, termination of

employment or reduction in number of hours of employment, or you no longer reside, live or work in the service area of a health maintenance organization in which you participated.

- ***New Eligible Dependents***. If you initially declined enrollment for yourself or your Eligible Dependents and you later have a new Eligible Dependent because of marriage, registered domestic partnership, birth, adoption, or placement for adoption, you may enroll yourself and your new Eligible Dependents (including a previously Eligible Dependent Spouse/Domestic Partner if you have a new Eligible Dependent Child), as long as you request enrollment within 31 days of the marriage, birth, adoption, or placement for adoption. For example, if you and your previously Eligible Dependent Spouse have a Child, you may enroll yourself, your previously Eligible Dependent Spouse and your new Child in the Plan, even if you were not previously enrolled. You will not, in this case, have a special enrollment right with respect to existing Eligible Dependent Children for whom coverage has been waived in the past. However, you may also enroll your existing Eligible Dependents under the Plan's Qualified Status Change Event rules.

  Your or your Eligible Dependent's participation will start as of the date of the birth, adoption, or placement for adoption, and for marriage/domestic partnership the first day of the calendar month following the date you submit your election change, so long as you timely request enrollment and provide proof of your dependent's status as an Eligible Dependent to the Aflac Benefits Department. The change in your Benefit Contributions will begin on the first payroll period following your election change request.

  You will need to enroll your new Eligible Dependents before the date that is 31 days after the event by which they became your Eligible Dependent (for example, a new Spouse after your marriage or your baby is born). If you do not add new Eligible Dependents within this 31-day period, you cannot enroll them until the next Annual Enrollment Period, Special Enrollment Period, or unless a Qualified Status Change Event occurs. You will need to provide proof of your dependent's status as an Eligible Dependent.

- ***Medicaid and CHIP***. If you or your Eligible Dependent Children are eligible for, but not enrolled in, the Plan and you or your Eligible Dependent Children:

  - lose coverage under Medicaid or a State child health plan (CHIP), or

  - become eligible for a premium assistance subsidy through Medicaid or CHIP,

    you and your Eligible Dependent Children may enroll in the Plan, as long as you request enrollment within 60 days of the loss of coverage or the date you or your Eligible Dependent Children became eligible for the premium subsidy. You will need to provide proof of your dependent's status as an Eligible Dependent. Your enrollment will take effect no later than the date of the loss of coverage or premium assistance eligibility. The date of the change in your Benefit Contributions will begin on the first payroll period following your election change request.

These 31-day and 60-day periods are "**Special Enrollment Periods.** Your **Enrollment Date** is the first day you are eligible – generally your hire date. Also, if you are covered under a medical benefit option and experience any Special Enrollment Right, you may drop your medical coverage under the Plan to enroll in coverage through the Health Insurance Marketplace. To drop your coverage, the Marketplace coverage for you and any Eligible Dependents who will lose medical coverage under the Plan must be effective no later than the day following the last day of your coverage under the Plan.

FMLA, Medical, or STD Leave

A **Group Health Plan** is an employee welfare benefit plan to the extent the plan provides medical care (including items or services paid for as medical care) to employees (and former employees) or their dependents directly or through insurance, reimbursement or otherwise.

Participation During a Leave of Absence. With Aflac's approval, you may take a medical leave of absence for up to 26 weeks or a short term disability ("**STD**") leave of absence and continue to participate in the Plan benefit options you were enrolled in immediately prior to your leave, provided you make the appropriate Benefit Contributions. Similarly, you may also continue to participate in the Plan options you were enrolled in immediately prior to your leave during a workers' compensation leave provided you make the appropriate Benefit Contributions.

Under the Family and Medical Leave Act of 1993, as amended ("**FMLA**"), you may qualify for up to a 12 week leave of absence or a 26 week service member caregiver leave of absence, which will run concurrently with a medical leave of absence, STD leave of absence, or a workers' compensation leave of absence. With Aflac approval you may take an FMLA leave of absence and remain a participant in the Plan during this time. You will be entitled to receive the same Plan benefits that you were receiving immediately before the start of your FMLA leave, provided you make the appropriate Benefit Contributions.

If you do not wish to receive some or all of the coverage during your leave (whether FMLA or non-FMLA) that you were receiving just prior to your leave, you must inform Aflac's Benefit Department before the start of your leave of absence. Such benefits under the Plan will terminate on the date you start your leave of absence.

If you are taking a paid leave of absence (FMLA, medical, or STD leave) and you do not cancel your coverage before the start of your leave, Aflac will continue to make payroll deductions to collect your Benefit Contributions for the coverage for which you are currently required to make contributions.

If you are taking an unpaid leave of absence (FMLA or medical), and you are currently required to contribute a certain amount for your coverage, you must make arrangements with the Aflac Benefits Department to pay for the coverage you wish to maintain during the course of your leave. You can pay for your Benefit Contributions:

- In advance of your leave with after-tax payments.
- During your leave by sending a check or money order to the Aflac Benefits Department on a monthly basis.

If Aflac advances money by making Benefit Contributions for you, in whole or in part, it can recoup the amounts advanced through payroll deductions upon your return to employment following your leave.

Workers' Compensation Leave

If you are taking a workers' compensation leave of absence (that does not qualify for FMLA), and you do not cancel your coverage before the start of your leave, you must pay for the coverage you wish to maintain during your leave by sending a check or money order to the Aflac Benefits Department on a monthly basis.

You should refer to Aflac's Leave of Absence Policy and consult with your HR Representative before taking any leave.

Qualified Status Change Events

You cannot change your benefit elections during the Plan Year unless you experience a Qualified Status Change Event, and the change you want to make is consistent with the event.

For insignificant increases or decreases in your Benefit Contributions during the Plan Year for your elected benefits, Aflac will automatically change your Benefit Contributions on a prospective basis. The Plan Administrator in its sole discretion and on a uniform and consistent basis will determine whether an increase or decrease is significant.

Any of the following events are Qualified Status Change Events:

- You or your Eligible Dependent become eligible or ineligible for coverage on account of a change in:
  - legal marital status (for example: marriage, registration of a domestic partnership, divorce, legal separation, cessation of a domestic partnership, annulment);
  - number of dependents (for example: birth, death, adoption, placement for adoption);
  - your employment status or your Eligible Dependent's employment status (for example, termination or commencement of employment, taking or returning from an unpaid leave of absence - including those protected under the FMLA, changing from part-time to full-time, or union to non-union, or *vice versa*);
  - residence or work site; or
  - a dependent's status (for example, a dependent becomes eligible or ineligible for benefits under the Plan). *You must provide proof of a change in an Eligible Dependent's status to the Aflac Benefits Department.*

Remember the Status Change Event Must Cause a Gain or Loss of Eligibility
The Qualified Status Change Event must cause you or your Eligible Dependents to gain or lose coverage under this Plan or another Group Health Plan and your election changes must be consistent with the Qualified Status Change Event.

- A change in coverage due to an election made by your Eligible Dependent under the Eligible Dependent's employer's benefit plan if:
  - the other employer plan has a different Annual Enrollment period that relates to a period that is different from the Plan Year for this Plan (for example, your Spouse's Annual Enrollment period is in January and your Spouse changes coverage); or
  - the other employer plan allows an election change for a Qualified Status Change Event as provided under the cafeteria plan regulations.
- A change in the availability of benefit options or coverage (addition or removal) under the Plan or under your Spouse's or dependent's employer's benefit plan (for example, a new HMO or PPO option is added to the Plan).
- A significant increase or decrease in the cost of coverage during the Plan Year. The Plan Administrator in its sole discretion and on a uniform and consistent basis will determine whether an increase or decrease is significant.
- You or your Eligible Dependent becomes eligible for COBRA Continuation Coverage or extended coverage under USERRA.
- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal guardianship (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires health coverage for your Child under this Plan or requires another individual to provide coverage to the Child, and that other coverage is provided.
- You or your Eligible Dependent becomes enrolled or loses coverage under Part A or Part B of Medicare or Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines).
- You or your Eligible Dependent loses coverage under any group health coverage sponsored by a government or educational institution, including a State children's health program (CHIP); a medical care program of an Indian Tribal government, the Indian Health Service or a tribal organization; a State health benefits risk pool; or a Foreign government group health plan.
- You or your Eligible Dependent are eligible for a Special Enrollment Period.

- Additional Change in Status Event for ACA Eligible Employees:
    - If you are an ACA Eligible Employee and your employment status changes so that you are no longer expected to average at least 30 hours per week, you may drop medical coverage under the Plan to enroll in another plan that provides minimum essential coverage such as your spouse's plan or coverage purchased through the Health Insurance Marketplace.
    - To be eligible for this change, the other coverage for you and any Eligible Dependents who will lose coverage must be effective no later than the first day of the second month after the date coverage under the Plan is revoked (*e.g.*, if coverage is revoked in August, coverage under the new plan must begin on October 1).

Consistency Rule
Your election changes must be consistent with the Qualified Status Change Event that affects your coverage under the Plan. For example:

- if one of your Eligible Dependents no longer qualifies as an Eligible Dependent, you could cancel coverage for that dependent, but you could not cancel coverage for your other Eligible Dependents; or
- if you have single coverage and you marry, you may elect family coverage.

Some of the Status Change Events may allow you the option of either adding or removing coverage. For example, your Spouse changing an election under his or her employer's plan may allow you to add or remove coverage under this Plan, so long as your choice is consistent with your Spouse's election.

If you are not sure the election change you would like to make is consistent with the Qualified Status Change Event, you should contact the Aflac Benefits Department.

Procedures for Changing Elections Mid-Year
If you want to change a Plan election because of one of these Qualified Status Change Events, you may do so by filing a request within 31 days of the date of the Qualified Status Change Event. You will need to identify the event that resulted in the change and specify how you want your elections changed. You must also submit proof of the Qualified Status Change Event to the Aflac Benefits Department within 31 days of the date of the Qualified Status Change Event. If you file a request after the 31-day period, no changes will be made to your elections, coverage or Benefit Contributions, but you may make the necessary change during the next Annual Enrollment Period.

For a dependent who no longer qualifies as an Eligible Dependent, the change in coverage will automatically take effect as of the end of the month the dependent is no longer eligible for the Plan, regardless of whether you request an election change within the 31 day period. Failure to inform the Plan that a dependent is no longer eligible for coverage is considered an intentional misrepresentation of material fact entitling the Plan to rescind the dependent's coverage. The Plan has the right to recover from you any payments the Plan makes on behalf of the individual.

Ineligible Dependents
Remember, failing to notify the Plan that a dependent is no longer eligible for coverage is an intentional misrepresentation of material fact. The Plan will automatically remove a dependent who no longer qualifies as an Eligible Dependent, as of the date the dependent is no longer eligible, even if the Plan learns of the ineligibility at a later date. Your intentional misrepresentation of material fact entitles Aflac to recover from you any payments made by the Plan on behalf of an ineligible dependent.

Employee Not Actively at Work

Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer but not currently active due to health status.

Reinstatement of Coverage

If the Employee terminates employment for any reason and is rehired within 30 days, coverage may be reinstated automatically.

Who Pays For Your Benefits And Method Of Funding Benefits

The medical benefits paid under this plan are self-funded by Aflac as Plan Sponsor and by you, the Member, through your Benefit Contributions for yourself and your family.

You are also responsible for Coinsurance, Copayments and Deductibles that may be required under the terms of the Plan.

The benefits provided under the Plan will be paid, to the extent permitted under ERISA and the Code, from the general assets of Aflac and employee contributions. Nothing in this Plan will be construed to require Aflac to maintain any fund for its own contributions or segregate any amount which it is obligated to contribute for the benefit of any participant, and no participant or other person will have any Claim against, right to, or security or other interest in, any fund, account or asset of Aflac from which any payment under the Plan may be made.

From time to time Aflac may adjust or change the amount of contributions required by you for coverage in this Plan. In addition, the deductions and co-payments may also change periodically. You will be notified of any changes in the cost of Plan coverage.

RETIREE ELIGIBILITY AND PARTICIPATION

You may enroll for coverage within 60 days of the date you elect early retirement from Aflac and qualify as an eligible early Retiree under this Plan.

In addition, by qualifying as an early Retiree, you will also have terminated your employment with Aflac, and as a result will be entitled to continue your medical coverage under the Plan through COBRA Continuation Coverage in lieu of electing to participate as a Retiree.

You will have 60 days from the date you receive the COBRA notice to decide whether to elect COBRA continuation coverage under the Plan. You may participate in either COBRA continuation coverage or in coverage under this Plan as a Retiree, but not both at the same time.

Please see the COBRA Continuation Coverage Section of this Benefit Booklet for the definition of a “qualifying event” and a full discussion of your COBRA rights.

Your coverage under this Plan as an early Retiree continues until you reach age 65 or otherwise lose coverage because you become eligible for Medicare or another employer’s health plan, stop paying your required premiums, or otherwise lose coverage under the terms of the Plan (for example, due to fraud). On the other hand, COBRA continuation coverage is a temporary continuation of coverage for the Retiree for 18 months after your qualifying event (unless extended for an additional 11 months because of disability).

Dependent Enrollment

Retirees must enroll Eligible Dependents who are currently covered under the Plan at the time of initial enrollment as a qualifying Retiree. If a Retiree does not have any Eligible Dependents at the time of initial enrollment, but acquires Eligible Dependents at a later date, the Retiree must enroll the Dependent(s) within 31 days of the date acquired.

To enroll, you must complete and return any enrollment forms required or provided by Aflac within the applicable time period. You may also enroll your Eligible Dependents during the Annual Enrollment Period. You may be required to obtain and provide the Claims Administrator with a Social Security number for each covered

Dependent. Please remember that you must pay the full cost of coverage for any Eligible Dependent you wish to add to coverage in this Plan who was not a covered Dependent in this Plan on the last day you were covered under the Plan as an active Employee.

Newborn and Newly Adopted Children

Your newborn or newly adopted child is not covered under this Plan unless you notify the Plan and elect coverage for the child within 31 days of the date of birth or adoption. If your child is properly enrolled, coverage will begin on the date of the child's birth or adoption. You must pay the full cost of coverage for any newborn or newly adopted child you wish to add to coverage in this Plan after you begin participating as a Retiree.

Change In Status

You are allowed to change your enrollment elections during the Plan Year if you have a Qualified Status Change Event. If you have a Qualifying Status Change Event, you may change your enrollment election within 31 days of the change in status by notifying the Aflac Employee Benefits Department and completing and returning any required forms. Your change in enrollment election must be consistent with your change in status. In other words, you may only change your election if the change in status causes you, or your Eligible Dependent to gain or lose eligibility for coverage under this or another plan, and the election change must correspond with the effect on coverage.

See the discussion above regarding Qualified Status Change Events for active employees for more information.

Cost For The Retiree's Coverage

Aflac pays a percentage of the cost of providing medical benefits for the Retiree and you also pay a percentage of the cost of providing medical benefits for you as the Member. Together, you and Aflac, are the source of financing 100% of the cost of the Plan's medical benefits.

Cost For The Dependent's Coverage

Aflac also pays a percentage of the cost of providing medical benefits for your Eligible Dependents, if your dependent was a Member in the Plan at the time you became a Retiree. In the event someone becomes your Eligible Dependent after you have become a Retiree of Aflac and after you become a Member in the portion of this Plan providing Retiree coverage, and you wish to add such Eligible Dependent for coverage under this Plan, you must pay the full cost of providing medical benefits under this Plan for such Dependent. Aflac will not pay a percentage of the cost of providing medical benefits for such Dependent. The "full cost" of coverage for an Eligible Dependent shall be the cost of purchasing individual coverage under the Plan. Also, if you had an Eligible Dependent at the time you became a Retiree who was not a Member in the Plan at the time you elected to participate in this Plan as a Retiree, and you wish to add such Dependent for coverage under this Plan, you must pay the full cost of providing medical benefits under this Plan for such Dependent. Aflac will not pay a percentage of the cost of providing medical benefits for such Dependent.

HOW YOUR PLAN WORKS

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

Introduction

Your health plan is a Preferred Provider Organization (PPO) for all Members except residents of Georgia. Members residing in Georgia are part of a Point of Service (POS) plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If you choose a Network Provider, you will receive Network benefits. **Members who are residents of Georgia must use the appropriate POS Network Provider to receive Network benefits.** Utilizing this method means you will not have to pay as much money; Your Out-of-Pocket expenses will be higher when you use Out-of-Network Providers.

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

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

BlueCard® PPO Program

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

The BlueCard program helps reduce your costs when you access covered Out-of-Network care throughout the United States (to receive Network benefits, you must use a provider in the BlueCard PPO program). Simply show your Identification Card with the PPO in a suitcase logo, and you will benefit from discounts that these BlueCard providers have agreed to extend to their local Blue Cross and/or Blue Shield Plan. Be sure to verify that the provider participates in the BlueCard Program. To do so, visit www.anthem.com and select the "Traditional/Indemnity" network. Services rendered by these providers will be considered Out-of-Network, but will generally cost less than services provided by other Out-of-Network Providers.

There are three ways you can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers and Facilities that participate in this Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the Member Services number on the back your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help your needs

Care Outside the United States – Blue Cross Blue Shield Global Care

Prior to travel outside the United States, check with your Group or call Member Services at the number on your Identification Card to find out if your Plan has Blue Cross Blue Shield Global Care benefits. Your coverage outside the United States may be different and we recommend:

- Before you leave home, call the Member Services number on your Identification Card for coverage details.
- Always carry your current Identification Card.

- In an emergency, go directly to the nearest Hospital.
- The Blue Cross Blue Shield Global Care Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- You need to find a Physician or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.
- You need to be hospitalized or need Inpatient care. After calling the Service Center, You must also call the Claims Administrator to obtain approval for benefits at the phone number on your Identification Card. **Note:** This number is different than the phone numbers listed above for Blue Cross Blue Shield Global Care.

Payment Information

- **Participating Blue Cross Blue Shield Global Care Hospitals.** In most cases, when you make arrangements for hospitalization through Blue Cross Blue Shield Global Care, you should not need to pay upfront for Inpatient care at participating Blue Cross Blue Shield Global Care hospitals except for the Out-of-Pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should submit your claim on your behalf.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the Blue Cross Blue Shield Global Care Service Center. Then you can complete a Blue Cross Blue Shield Global Care claim form and send it with the original bill(s) to the Blue Cross Blue Shield Global Care Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the Blue Cross Blue Shield Global Care Service Center arranged your hospitalization. You will need to pay the Hospital for the Out-of-Pocket costs you normally pay.
- You must file the claim for outpatient and Physician care, or Inpatient care not arranged through the Blue Cross Blue Shield Global Care Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

Claim Forms

International claim forms are available from the Claims Administrator, the Blue Cross Blue Shield Global Care Service Center, or online at www.bcbsglobal.com. The address for submitting claims is on the form.

Copayment

Certain Network services may be subject to a Copayment amount which is a flat-dollar amount you will be charged at the time services are rendered.

Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the **Schedule of Benefits**. Unless otherwise indicated, services which are not specifically identified in this Benefit Booklet as being subject to a Copayment are subject to the **calendar year Deductible** and payable at the **percentage payable** in the **Schedule of Benefits**.

Calendar Year Deductible

Before the Plan begins to pay benefits, you must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the Schedule of Benefits. Deductible requirements are stated in the Schedule of Benefits.

Claims and Appeals. Please see the **"Claims Payment"** and **"Your Right to Appeal"** portions of this Benefits Booklet for important information about how to make a claim for benefits and the time limits for submitting a benefit claim or appealing a denied claim, and the section entitled "**Deadline for Filing a Lawsuit**" for important information about the applicable deadlines for filing a lawsuit.

HEALTH CARE MANAGEMENT – PRE-CERTIFICATION

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Benefit Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/place of care.

Certain Services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. It may be decided that a service that was asked for is not Medically Necessary if you have not tried other treatments that are more cost effective.

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

Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides your services are Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Benefit contributions must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Types of Reviews:

- **Pre-service Review –** A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.

- **Precertification –** A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Benefit Booklet.

  For admissions following Emergency Care, you, your authorized representative or Doctor must tell the Claims Administrator within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

- **Continued Stay/Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected

to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

The following is a list of services under the Plan that require precertification before any benefits are payable. The following list is not all inclusive and is subject to change; please call the Member Services telephone number on your Identification Card to confirm the most current list and requirements for your Plan.

- **Inpatient Admission:**
  - Acute Inpatient
  - Acute Rehabilitation
  - LTACH (Long Term Acute Care Hospital)
  - Skilled Nursing Facility
  - OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)
  - Emergency Admissions (Requires Plan notification no later than 2 business days after admission)
- **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
- **Durable Medical Equipment (DME)/Prosthetics:**
  - Augmentative and Alternative Communication (AAC) Devices/ Speech Generating Devices (SGD)
  - Dynamic Low-Load Prolonged-Duration Stretch Devices
  - 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)
  - Ultrasound Bone Growth Stimulation
  - Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)
  - Prosthetics: Electronic or externally powered and select other prosthetics- (myoelectric-UE)

- Standing Frame

- **Gender Reassignment Surgery**
- **Human Organ and Bone Marrow/Stem Cell Transplants**
  - Inpatient admits 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 replacement therapy intended to treat retinal dystrophies
  - Intrathecal treatment of Spinal Muscular Atrophy (SMA)
- **Outpatient and Surgical Services:**
  - Air Ambulance (excludes 911 initiated emergency transport)
  - Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
  - Ablative Techniques as a Treatment for Barrett's Esophagus
  - Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
  - Bariatric Surgery and Other Treatments for Clinically Severe Obesity
  - Bone-Anchored and Bone Conduction Hearing Aids
  - Bronchial Thermoplasty for Treatment of Asthma

    <u>Cardio-Vascular</u>
    - ► 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
    - ► Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
    - ► Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
    - ► Implantable or Wearable Cardioverter-Defibrillator
    - ► Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
    - ► Mechanical Embolectomy for Treatment of Acute Stroke
    - ► Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
    - ► Partial Left Ventriculectomy
    - ► 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
    - ► Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
    - ► Treatment of Varicose Veins (Lower Extremities)
    - ► Venous Angioplasty with or without Stent Placement/ Venous Stenting
  - Cochlear Implants and Auditory Brainstem Implants
  - Corneal Collagen Cross-Linking

- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation pacing systems
- Electric Tumor Treatment Field (TTF) for treatment of glioblastoma
- Functional Endoscopic Sinus Surgery
- Immunoprophylaxis for respiratory syncytial virus (RSV)
- Implantable Middle Ear Hearing Aids
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Lumbar Discoraphy
- Lung Volume Reduction Surgery
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)

  Musculo-Skeletal Surgeries
  - ► Axial Lumbar Interbody Fusion
  - ► Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
  - ► Extracorporeal Shock Wave Therapy for Orthopedic Conditions
  - ► Implanted Devices for Spinal Stenosis
  - ► Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
  - ► Lysis of Epidural Adhesions
  - ► Manipulation Under Anesthesia of the Spine and Joints other than the Knee
  - ► Meniscal Allograft Transplantation of the Knee
  - ► Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
  - ► Sacroiliac Joint Fusion
  - ► Total Ankle Replacement
  - ► Treatment of Osteochondral Defects of the Knee and Ankle
- Occipital nerve stimulation
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Perirectal Spacers for Use During Prostate Radiotherapy (Space Oar)
- Private Duty Nursing
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Plastic/Reconstructive Surgeries/ Treatments**:**
  - ► Abdominoplasty ,Panniculectomy, Diastasis Recti Repair
  - ► Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting Hyperbaric Oxygen Therapy (Systemic/Topical)
  - ► Blepharoplasty
  - ► Brachioplasty
  - ► Breast Procedures; including Reconstructive Surgery, Implants and other Breast Procedures
  - ► Chin Implant, Mentoplasty, Osteoplasty Mandible
  - ► Insertion/injection of prosthetic material collagen implants

- ► Liposuction/lipectomy
- ► Mandibular/Maxillary (Orthognathic) Surgery
- ► Mastectomy for Gynecomastia
- ► Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- ► Penile Prosthesis Implantation
- ► Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
- ► Procedures Performed on Male or Female Genitalia
- ► Procedures Performed on the Trunk and Groin
- ► Reduction Mammaplasty
- ► Repair of pectus excavatum/carinatum
- ► Skin-Related Procedures

- 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
- 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)
- Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
- Treatment of Hyperhidrosis
- Treatments for Urinary Incontinence
- Transcatheter Uterine Artery Embolization
- Treatment of Temporomandibular Disorders –
- Vagus Nerve Stimulation
- Viscocanalostomy and Canaloplasty

- **Radiation Therapy/Radiology Services:**
  - Intensity Modulated Radiation Therapy (IMRT)
  - Magnetic Source Imaging and Magnetoencephalography (MSI/MEG)
  - Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
  - Proton Beam Therapy
  - 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 the Patency Capsule

- **Out-of-Network Referrals:**

Out-of-Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or medical necessity.)

- **Mental Health/Substance Abuse (MHSA):**

Pre-Certification Required

Aflac
PPO Plan

- ABA - Applied Behavioral Analysis
- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care

Utilizing a Provider outside of the Network may result in significant additional financial responsibility for you, because the Plan cannot prohibit Out-of-Network Providers from billing you for the difference between the Provider's charge and the benefit the Plan provides.
The ordering Provider, Facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is Responsible for Precertification?
Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Anthem Blue Cross Blue Shield (GA); and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.	Provider	• The Provider must get Precertification when required

Provider Network Status	Responsibility to Get Precertification	Comments
Out-of-Network/Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
Blue Card Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed	Member (Except for Inpatient Admissions)	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **Blue Card Providers must obtain Precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time.		

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventative care clinical coverage guidelines, to assist in making Medical Necessity decisions. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically. The Plan document takes precedence over these guidelines.

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

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

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

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

You may determine whether a Provider is participating in certain programs by contacting the Member Services number on the back of your ID Card.

Request Categories:

- **Urgent –** a request for Pre-certification or Pre-determination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or

treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective –** a request for Pre-certification or Pre-determination that is conducted prior to the service, treatment or admission.
- **Concurrent -** a request for Pre-certification or Pre-determination that is conducted during the course of treatment or admission.
- **Retrospective -** a request for Pre-certification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

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

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent/Continued Stay Review Non-Urgent for ongoing outpatient treatment	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

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

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

- Verbal: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.
- Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Member or authorized Member representative.

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

1. You must be eligible for benefits;
2. Benefit contributions must be paid for the time period that services are given;
3. The service or surgery must be a covered benefit under your Plan;
4. The service cannot be subject to an exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Care Management

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

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

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

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

Claims and Appeals. Please see the **"Claims Payment"** and **"Your Right to Appeal"** portions of this Benefits Booklet for important information about how to make a claim for benefits and the timeframes for submitting a benefit claim and appealing a denied claim, and the section entitled "**Deadline for Filing a Lawsuit**" for important information about the applicable deadlines for filing a lawsuit.

BENEFITS

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details.

All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

Claims and Appeals. Please see the **"Claims Payment"** and **"Your Right to Appeal"** portions of this Benefits Booklet for important information about how to make a claim for benefits and the timeframes for submitting a benefit claim and appealing a denied claim, and the section entitled "**Deadline for Filing a Lawsuit**" for important information about the applicable deadlines for filing a lawsuit.

Ambulance Service

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;

- Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to a Network Hospital
- Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of Your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Doctor's office or clinic;
- A morgue or funeral home.

Important Notes on Air Ambulance Benefits
Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or a rehabilitation Facility or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport
If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Applied Behavioral Analysis (ABA)
Applied Behavioral Analysis is a efficacy-based medical health service that is the treatment of choice for many symptoms of Autism Spectrum Disorder.

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

Behavioral Health Care and Substance Abuse Treatment
See the **Schedule of Benefits** for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable

than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Covered Services include the following:

- **ABA Therapy** – Medically Necessary applied behavioral analysis services.

- **Inpatient Services** in a Hospital or any facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.

- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - observation and assessment by a psychiatrist weekly or more often; and
  - rehabilitation, therapy, and education.

- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs

Methadone Clinic Services – where a person who is addicted to opioid-based drugs, such as heroin or prescription painkillers, can receive medication-based therapy. Methadone for these addictions can only be obtained through a federally certified clinic. It cannot be obtained through a pharmacy.

- ***Live Health Online* – Online Visits** when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Examples of Providers from whom you can receive Covered Services include:
- Psychiatrist;
- Psychologist;
- Licensed Clinical Social Worker (L.C.S.W.);
- mental health clinical nurse specialist;
- Licensed Marriage and Family Therapist (L.M.F.T.);
- Licensed Professional Counselor (L.P.C); or
- Any agency licensed by the state to give these services, when they have to be covered by law.

Breast Cancer Care

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

Breast Reconstructive Surgery

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

Cardiac Rehabilitation

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

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

    a. The National Institutes of Health.

    b. The Centers for Disease Control and Prevention.

    c. The Agency for Health Care Research and Quality.

    d. The Centers for Medicare & Medicaid Services.

    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

        i. The Department of Veterans Affairs.

        ii. The Department of Defense.

        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

Routine patient care costs include items, services, and Drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

- The Experimental/Investigative item, device, or service;
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

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

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

Dental Services
Related to Accidental Injury
Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury.

"Initial" dental work to repair injuries due to an accident means performed within 12 months from the Injury or within 12 months of the Member's Effective Date. Treatment must be completed within 24 months of the initial treatment.

Other Dental Services
Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:
- The Member is under the age of five (5);
- The Member has a severe impairment that requires hospitalization or general anesthesia for dental care; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes
Equipment and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

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

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

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

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation will not be covered. 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.

Benefits for Durable Medical Equipment include coverage for contraceptive devices, implants, and injectables.

Emergency Care

Life-threatening Medical Emergency or serious Accidental Injury.
Coverage is provided for Hospital emergency room care, including a medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition, and such further medical or behavioral health examination and treatment as are required to Stabilize the patient that are within the capabilities of the staff and Facilities available at the Hospital.

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

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:

- the median of the amount negotiated with Network Providers for the Emergency Service furnished, without regard to copayments and coinsurance;
- the amount for the Emergency Service calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network services, but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
- the amount that would be paid under Medicare for the Emergency Service, without regard to copayments or coninsurance.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network Providers are shown in the Schedule of Benefits.

Gender Reassignment Surgery

Your Plan provides benefits for many of the charges for sex reassignment surgery for Members diagnosed with Gender Dysphoria. Sex reassignment surgery must be approved by Anthem for the type of surgery requested and must be authorized prior to being performed. Charges for services that are not authorized for the sex reassignment surgery requested will not be considered Covered Services. Some conditions apply, and all services must be authorized by Anthem.

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See Health Care Management - Precertification for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is a Network Provider for other services it may

not be an approved Provider for certain gene therapy services. Please call us to find out which providers are approved Providers. (When calling Member Services, ask for the transplant case manager for further details.)
Services Not Eligible for Coverage
Your Plan does not include benefits for the following:
a. Services determined to be Experimental/Investigational;
b. Services provided by a non-approved Provider or at a non-approved Facility; or
c. Services not approved in advance through Precertification.

General Anesthesia Services

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

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

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

Habilitative Services

Benefits also include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Home Health Care Services

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

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Member must be essentially confined at home.

<u>Covered Services:</u>

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

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

Hospice Care Services

You are eligible for Hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely to have less than twelve (12) months to live. You may access Hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- social services and counseling services from a licensed social worker;
- nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and
- bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties for one year after the Member's death.

Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request. Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to, chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Benefit Booklet.

Hospital Services

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

Network

Inpatient Services

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

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

Length of Stay
- Determined by Medical Necessity.

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

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

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

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

Covered Transplant Benefit Period
At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts 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. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

Prior Approval and Precertification
In order to maximize your benefits, the Claims Administrator strongly encourages you to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. The Claims Administrator will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and

whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Member Services telephone number on the back of your Identification Card **and ask for the transplant coordinator.** Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, you or your Provider must call the Claims Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

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

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

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

Maternity benefits are provided for a female Employee or female Spouse of the Employee only.

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

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (**Note:** You must enroll your newborn child in the Plan within 31 days of the child's birth. If you fail to enroll your child during this 31-day period, you will not be able to enroll your new child in the Plan until the next Annual Enrollment Period, unless you experience another Qualified Status Change Event before that time. See "Special Enrollment Period" in the "Eligibility" section above for important information about how to add a newborn to your coverage.)

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

The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Member's attending Physician.

Abortion (Therapeutic) - Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape.

Contraceptive Benefits
Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Infertility Services
Your Plan also includes benefits for the diagnosis and treatment of an underlying medical condition. Covered Services include diagnostic and exploratory procedures to determine whether a Member suffers from Infertility. This includes surgical procedures to correct any diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. See the **Schedule of Benefits** for benefit limitations and Coinsurance amounts.

Sterilization Services
Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

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

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

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

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

Online Visits
When available in your area, your coverage will include online visits from a LiveHealth Online Provider. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See **Schedule of Benefits** for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. For Behavioral Health and Substance Abuse Online Visits, see the "Behavioral Health Care and Substance Abuse Treatment" section. Online visits are not covered from Providers other than those contracted with LiveHealth Online. Non-Covered Services include, but are not limited to communications used for:

- reporting normal lab or other test results;
- office appointment requests;
- billing, insurance coverage or payment questions;
- requests for referrals to Physicians outside of the online care panel;
- benefit precertification; and
- Physician to Physician consultation.

Oral Surgery

Covered Services include only the following:

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

Other Covered Services

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

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

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Out-of-Network Hospital Benefits

If you are confined in an Out-of-network Hospital, your benefits will be significantly reduced, as explained in the Schedule of Benefits section. **Note:** Care received Out-of-network for a Medical Emergency will be provided at the Network level of benefits if the following conditions apply: A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to serve pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.

Outpatient Surgery

Network Hospital outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular plan benefits. These benefits are subject to both Deductible and percentage payable (Coinsurance) requirements. Benefits for treatment by an Out-of-network Hospital are explained under “Hospital Services” and “Out-of-Network Hospital Benefits”.

Physical Therapy, Occupational Therapy, Chiropractic Care

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

Physician Services

You may receive treatment from a Network or Out-of-network Physician. However, payment is significantly reduced if services are received from an Out-of-network Physician. Such services are subject to your Deductible and Out-of-Pocket requirements. Consultations between your Primary Care Physician and a Specialty Care Physician are included, when approved by Anthem.

Preventive Care

Preventive care services include screenings and other services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

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

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

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

   a. Breast cancer;
   b. Cervical cancer;
   c. Colorectal cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. Child and Adult Obesity.

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

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

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

   a. Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.

   b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

   c. Gestational diabetes screening.

5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:

   a. counseling;

   b. Prescription Drugs; and

   c. Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

   a. aspirin;

   b. folic acid supplement;

   c. vitamin D supplement;

   d. iron supplement; and

   e. bowel preparations.

   Please note that certain age and gender and quantity limitations apply.

You may call Member Services using the number on Your ID card for additional information about these services. (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.)

Prosthetic Appliances

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

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

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

Reconstructive Surgery

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

Reconstructive surgery is covered only to the extent Medically Necessary:

- To correct significant anatomic deformities which are not within normal anatomic variation and which are caused by congenital or developmental abnormalities, illness, or Injury for the purpose of improving the significant anatomic deformity toward a normal appearance.
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Retail Health Clinic

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

Skilled Nursing Facility Care

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

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and

- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

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

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

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

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

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

Prescription Drugs Administered by a Medical Provider
This Plan covers Prescription Drugs when they are administered to you as part of a Physician's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and injectables and any drug that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the separate retail and mail order Prescription Drug Benefit Program. Also, if Prescription Drugs are covered under the retail and mail order Prescription Drug Benefit Program they will not be covered under this benefit.

LIMITATIONS AND EXCLUSIONS

1. **Admissions for Non-Inpatient Services -** Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
2. **Administrative Charges -** Charges for any of the following:

a. Failure to keep a scheduled visit;

b. Completion of claim forms or medical records or reports unless otherwise required by law;

c. For Physician or Hospital's stand-by services;

d. For holiday or overtime rates.

e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provider their test results.

f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

3. **Allergy Services -** Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
4. **Alternative Therapies -** Hypnotherapy, acupuncture and acupuncture therapy. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki 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. This exclusion also applies to biofeedback, recreational, or educational sleep therapy or other forms of self-care or non medical self-help training and any related diagnostic testing.
5. **Before Coverage Begins / After Coverage Ends -** Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends. Such services and supplies shall include but not be limited to Inpatient Hospital admissions which begin before a Member's Effective Date, continue after the Member's Effective Date, and are covered by a prior carrier.
6. **Biomicroscopy -** Biomicroscopy, field charting or aniseikonic investigation.
7. **Comfort and Convenience Items -** Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
8. **Complications -** Complications of non-covered procedures are not covered.
9. **Cosmetic Services / Beautification Procedures -** Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by the Claims Administrator is not covered. (See sections a. and b. below.)

a. This exclusion does not apply to surgery to restore function if any bodily area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries that caused the impairment, or as

a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

b. This exclusion does not apply to post mastectomy Breast Reconstructive Surgery.

Standard complications directly related to cosmetic services treatment or surgery, as determined by The Claims Administrator, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier / self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

10. **Court-Ordered Services -** Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.
11. **Crime and Incarceration -** Injuries received while committing a crime as well as 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.
12. **Custodial Care and Rest Care -** Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain.
13. **Daily Room Charges -** Daily room charges while the Plan is paying for an Intensive care, cardiac care, or other special care unit.
14. **Dental Care -** Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; surgical removal of impacted teeth, dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
15. **Educational Services -** Educational services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to, services for conditions related to autistic disease of childhood (except to the same extent that the Plan provides for neurological disorders and applied behavioral analysis), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning impairments, behavioral problems, and mental and intellectual impairment. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
16. **Excessive Expenses -** Expenses in excess of the Plan's Maximum Allowed Amount.
17. **Employer or Association Medical / Dental Department -** Received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.
18. **Experimental / Investigational Services -** Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered

by a Member's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

19. **Family Members -** Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.
20. **Foot Care –** Routine foot care only to improve comfort or appearance, routine care of corns, (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
21. **Free Services -** Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
22. **Government Programs -** Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
23. Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.
24. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
25. **Hair –** Hair transplants, hair pieces or wigs) except when necessitated by disease) wig maintenance, or prescriptions or medications related to hair growth.
26. **Health Spa -** Expenses incurred at a health spa or similar facility.
27. **Ineligible Hospital -** Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
28. **Ineligible Provider -** Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
29. **Infertility Services -** For artificial insemination; fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization; Infertility drugs and related services following the diagnosis of Infertility. The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests.
30. **Inpatient Rehabilitation Programs -** Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Member is medically stable and does not require skilled nursing care or the constant availability of a Physician or:

a. the treatment is for maintenance therapy; or

b. the Member has no restorative potential; or

c. the treatment is for congenital learning or neurological disability/disorder; or

d. the treatment is for communication training, educational training or vocational training.

31. **International Services -** Non-emergency treatment of chronic illnesses received outside the United States performed without preauthorization. See the information on the BlueCard Worldwide program in this Benefit Booklet for further details.

32. **Maintenance Care -** Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury or condition which is resolved or stable.

33. **Marital Counseling -** Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

34. **Medicare -** Services for which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Benefit Booklet or as required by Federal law, as described in the section titled "Medicare" in **General Information**. If you do not enroll in Medicare Part B when you are eligible, and the Plan is permitted under Federal law to pay secondary to Medicare (for example, if you are a retiree or COBRA participant), you may have large Out-of-Pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

35. **Medications -** Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate Prescription Drug Benefit Program for retail and mail order drugs but not under the Medical Program. Although coverage for Outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a Hospital, in a Physician's Office or as part of a Home Health Care benefits. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.

36. 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. This Exclusion does not apply to over-the-counter products that the Plan must cover under federal law with a Prescription.

37. **Never Events –** The Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care facility. The Provider will be expected to absorb such costs. This Exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.

38. **Non-Covered Services -** Any item, service, supply or care not specifically listed as a Covered Service in this Benefit Booklet.

39. **Not Medically Necessary Services-** Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

40. **Obesity Services -** Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription drugs, or dietary control (except as related to covered nutritional counseling for diabetes). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to Enteral feeding except when it's the sole means of nutrition. Food supplements. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care, or counseling. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include, but are not limited to, specific bariatric services and surgeries (e.g., liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw.)

41. **Obesity Surgery -** For bariatric surgery, regardless of the purpose it is proposed or performed for. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or

gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by the Claims Administrator, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded Plan prior to coverage under this Plan. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

42. **Private Rooms -** Private room, except as specified as Covered Services.
43. **Research Screenings –** For examinations related to research screenings, unless required by law.
44. **Reversal of Sterilization -** Services related to or performed in conjunction with reverse sterilization.
45. **Routine Examinations -** Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms illness or Injury except those which may be specifically listed as covered in this Benefit Booklet.
46. **Safe Surroundings -** Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
47. **Sclerotherapy -** Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
48. **Services Not Specified as Covered.** No benefits are available for services that are not specifically described as Covered Services in this Benefit Booklet. This exclusion applies even if your Physician orders the service.
49. **Sexual Dysfunction -** Medical/ surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction) regardless of origin or cause. This exclusion also includes penile prostheses or Implants and vascular or artificial reconstruction, Prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
50. **Shoes and Orthotics -** Shoe inserts, orthotics (except when prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
51. **Spider Veins -** Treatment of telangiectatic dermal veins (spider veins) by any method.
52. **Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary -** Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to:
    i. Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards,
    ii. Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs,
    iii. The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment,
    iv. Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers,

v. Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a Member's house or place of business and adjustments made to vehicles.

vi. Air conditioners, humidifiers, dehumidifiers, or purifiers;

vii. rental or purchase of equipment if you are in a Facility which provides such equipment;

viii. consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications; and,

ix. Other items of equipment that the Claims Administrator determines does not meet the listed criteria.

53. **Telecommunication -** Advice of consultation given by any form of telecommunication, except as specifically covered under the Plan's Online Visits benefit.

54. **Therapy Services -** Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.

55. **Transplant Services -** The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:

    i. Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;

    ii. Donation related services or supplies, including search, associated with organ acquisition and procurement (except as otherwise indicated);

    iii. Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered; any transplant not specifically listed as covered;

    iv. Any transplant not specifically listed as covered.

56. **Transportation -** Transportation provided by other than a state licensed professional ambulance service, and Ambulance Services other than in a Medical Emergency. Transportation to another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.

57. **Travel Costs and Mileage -** For mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer.

58. **Thermograms -** Thermograms and thermography.

59. **Vision Care -** Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated in this Benefit Booklet. Service or devices to correct vision or for advice on such service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.

60. **Vision Surgeries -** Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

61. **Waived Fees -** Any portion of a provider's fee or charge which is ordinarily due from a Member but which has been waived. If a provider routinely waives (does not require the Member to pay) a

Deductible or Out-of-Pocket amount, the Claims Administrator will calculate the actual Provider fee or charge the fee or charge by the amount waived.

62. **War / Military Duty -** Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.
63. **Worker's Compensation -** Care for any condition or Injury recognized or allowed as a compensable loss through any Worker's Compensation, occupational disease or similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

CLAIMS PAYMENT

Providers who participate in the Blue Card® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the Blue Card® PPO network Hospitals, Physicians and Ancillary Providers are used, you usually will not have to file claims for their services with the Claims Administrator. In addition, many out-of-network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by visiting www.anthem.com.

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

How to File Claims

The Claims Administrator must receive the proper claim form with any necessary reports and records within 12 months after the service was provided. If you fail to meet this deadline, your claim will be automatically denied for failure to file timely. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for you.

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

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

For health care expenses other than those billed by a Network Provider, use the Member Health Expense Report to report your expenses. You may obtain these from your Employer or the Claims Administrator. Claims should include your name, Plan and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

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

Maximum Allowed Amount

General

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

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement the Plan will allow for services and supplies:

- that meet the Plan's definition of Covered Services;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Plan.

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

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

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

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

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

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

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

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

Unlike Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out of Pocket costs to you. Please call Member Services for help in finding a Network Provider or visit the Claims Administrator's website at www.anthem.com.

Member Services is also available to assist you in determining this/your Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your Out of Pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

Member Cost Share
For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this Benefit Booklet for your cost share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of Provider you use.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Network or Non Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

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

Authorized Services
In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must

contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization.

Services Performed During Same Session

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

Processing Your Claim

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

Timeliness of Filing − Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by you or your provider within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, you will be notified of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, the Claims Administrator will complete claims processing. Please see the "Your Right to Appeal" section below for important information, including important filing deadlines, about how you may request a review of your claim if you disagree with the Claim Administrator's decision.

Necessary Information

In order to process your claim, the Claims Administrator may need information from the provider of the service. As a participant in the Plan, you agree to authorize the Physician, Hospital, or other provider to release necessary information.

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

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Member's Cooperation

You will be expected to complete and submit to the Claims Administrator all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the primary responsible payer), you will be responsible for any charge for services.

Explanation of Benefits

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

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

Out-of-Area Services

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

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

BlueCard® Program

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

Whenever you access covered healthcare services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

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

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

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

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

You will be entitled to benefits for healthcare services that you accessed, either inside or outside the geographic area Anthem serves, if this Plan covers those healthcare services. Due to variations in Host Blue network

protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area Anthem serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them, that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

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

Unauthorized Use of Identification Card

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

Payment

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to you as opposed to any Provider for Covered Service. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or you) will discharge the Employer's obligation to pay for Covered Services.

No Assignments Permitted

No right, benefit, cause of action arising after the denial of benefits, or any other interest under this Plan shall be subject to alienation, sale, transfer, assignment, pledge, or encumbrance or charge, voluntary or involuntary, by operation of law or otherwise, and any attempt at such transaction(s) shall be void. You ***may not*** assign your rights, benefits, causes of action arising after the denial of benefits, or any other interest under this Plan to a Provider or any other individual or entity. The applicable Claims Administrator may, however, in its discretion, pay a Provider directly for services rendered to you or your covered Eligible Dependent(s) as outlined above. The payment of benefits directly to a Provider, if any, will be done as a convenience to you and your covered Eligible Dependent(s) and will not constitute an assignment of rights, benefits, causes of action, or any other interest under the Plan or a waiver of this anti-assignment provision.

Questions About Coverage or Claims

If you have questions about your coverage, contact the Claims Administrator's Member Services Department. Be sure to always give your Member Identification number.

When asking about a claim, give the following information:

- Identification number;
- Patient's name and address;
- date of service and type of service received; and

- provider name and address (Hospital or Physician).

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

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

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

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

Eligibility Claims

An "**Eligibility Claim**" is any written request for participation in the Plan that is made by you or your authorized representative. There are two types of Eligibility Claims, Pre-Service Eligibility Claims and Post-Service Eligibility Claims.

Pre-Service Eligibility Claims. A ***"Pre-Service Eligibility Claim"*** is a request for participation in the Plan that occurs before you incur any expenses. For example, Pre-Service Eligibility Claims include requests for participation made before you visit the doctor. This may occur if you believe a mistake was made during the Annual Enrollment Period.

Post-Service Eligibility Claims. A "**Post-Service Eligibility Claim**" is a request for participation in the Plan that occurs after you incur expenses. For example, Post-Service Eligibility Claims include requests for participation for your dependent Child made by you after your dependent Child incurs physician office visit expenses. This may occur if you mistakenly believed your dependent Child was enrolled in the Plan.

You must submit all Eligibility Claims in writing to the Aflac Benefits Department. If your Eligibility Claim is denied, you will be provided with written notice of the denial within 30 days after the date you submit your Eligibility Claim. If you disagree with the Eligibility Claim denial, you may file an internal appeal of that decision by submitting your request for internal review to the Aflac Benefits Department within 180 days of receiving the Eligibility Claim denial. The Aflac Benefits Department will forward your appeal to the Aflac Incorporated Health Administrative Committee. For Pre-Service Eligibility Claims, the Aflac Incorporated Health Administrative Committee will make its determination on your appeal during the next Committee meeting. For Post-Service Eligibility Claims, the Aflac Incorporated Health Administrative Committee will make its determination on your appeal within 60 days of the date you submit your appeal. The decision by the Aflac Incorporated Health Administrative Committee will be final and binding on all parties.

YOUR RIGHT TO APPEAL

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the Plan. The term includes pre-service, urgent care, concurrent care and post-service claims.

- A pre-service claim is a claim for benefits under the Plan for which you are required to obtain approval in advance (e.g., services that require preauthorization).
- An urgent care claim is a special type of pre-service claim. An urgent care claim is any pre-service claim for medical care or treatment with respect to which application of the time periods that otherwise apply to pre-service claims:
  - could seriously jeopardize the claimant's life or health or ability to regain maximum function; or
  - would, in the opinion of a physician with knowledge of the claimant's medical condition, cause the claimant severe pain that cannot be adequately managed without the treatment, service, or procedure that is the subject of the claim.
- A concurrent care decision occurs when the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of "concurrent care claims": (1) when reconsideration by the Plan of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; or (2) when the claimant wishes to extend the course of treatment beyond the initially approved period of time or number of treatments.
- A post-service claim is any other claim for benefits under the Plan. You have received the service.

If your claim is denied or if your coverage is rescinded:
- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

A "rescission" is a cancellation or discontinuance of coverage under the Plan, other than for a failure to timely pay required contributions, that has retroactive effect.

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

Notice of Adverse Benefit Determination

The Claims Administrator will respond to your claim within the time periods outlined under the heading "Claims Disclosure" in the "Statement of ERISA Rights" section of this Booklet. If your initial claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:
- information sufficient to identify the claim involved (the date of service, the health care Provider, and the claim amount when applicable);
- a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
- the specific reason(s) for the denial, including any denial code and its meaning and a description of any Plan standard used in denying the claim;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures, including any internal appeals or external review available, and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA and the deadline for filing such an action if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge.

For claims involving urgent/concurrent care:

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

Internal Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). **You or your authorized representative must file your appeal in writing within 180 calendar days after you are notified of the denial or rescission. Failure to comply with this important deadline will cause you to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.** You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Plan provides for a single mandatory level of internal appeal and an additional voluntary second level of internal appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.). These time periods are outlined below and under the heading "Claims Disclosure" in the "Statement of ERISA Rights" section of this Booklet.

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

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

Certain urgent care claims may be eligible for expedited external review with an independent review organization, in lieu of an internal appeal with the Claims Administrator. (See "Expedited External Review" below for additional information).

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

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 54159
Los Angeles, CA 90054

You must include Your Member Identification Number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or

- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

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

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

How Your Appeal will be Decided

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Concurrent Care Claims. The Claims Administrator will decide the appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision above) before the proposed reduction or termination takes place. The Claims Administrator will decide the appeal of a denied request to extend any concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service caims described above, as appropriate to the request.

Internal Appeal Denial

If your internal appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will generally include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination." If the decision is based on a Plan standard, the standard will be included in the notice, and the notice will include a discussion of the decision.

Voluntary Second Level Internal Appeals

If you are dissatisfied with the Plans mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. **Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal.**

Aflac
PPO Plan

Exhaustion of Administrative Remedies.

Neither you, your beneficiary, nor any individual may bring any legal action to recover benefits under the Plan or to enforce or clarify your rights under Section 502 or Section 510 of ERISA, or any other provision of law, whether or not statutory, until the above claim and internal review procedures have been exhausted in their entirety. See "Deadline for Filing a Lawsuit" below for important information about the deadline for filing a lawsuit after you have exhausted the Plan's claim and internal appeal procedures.

Requirement to File an Internal Appeal Before Requesting External Review or Filing a Lawsuit

If your claim is denied, in whole or in part, after you have completed the Plan's internal appeal procedure, you have the right to seek an external review (if your claim is eligible for external review, as described below), or file a civil action in federal court under ERISA. Important deadlines apply for filing a request for external review or a federal lawsuit, as explained in "External Review" and "Deadline for Filing a Lawsuit" below. Failure to comply with these important deadlines will cause you to forfeit any right to any further review of an adverse decision under the Plan's external review procedures or in a court of law.

External Review

If the outcome of the mandatory first level internal appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to Federal law.

You must submit your request for External Review to the Claims Administrator within four months of the notice of the denial of your appeal under the Plan's internal appeal procedures described above.

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

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

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

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

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 54159
Los Angeles, CA 90054
Fax: 888-859-3046

Aflac
PPO Plan

You can obtain more information about the Plan's external review process by calling the member services number on the back of your ID Card.

You must include Your Member identification number when submitting a request for External Review.

Requesting External Review is not an additional step that you must take in order to exhaust the Plan's claim and appeal procedures. 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 judicial review.

Deadline for Filing a Lawsuit

You may not take any legal action against the Plan, the Plan fiduciaries, the Employer, its agents or representatives or the Claims Administrator for the recovery of any claims unless you have exhausted the internal appeals procedures in this SPD for appealing a denied claim. A claimant must file a civil action pertaining to a claim within the earliest of the following dates:

- one year after the date the Claims Administrator has made a final determination of the claim or appeal in accordance with the applicable claims review procedures, or should have made the determination in accordance with the Plan's claims review procedures; or
- with respect to claims for benefits, one year from the date the service or treatment was provided; or
- with respect to Eligibility Claims, one year after the date the event giving rise to the Eligibility Claim occurred, *e.g.,* termination of active employment.

It is important that you include all the facts and arguments that you want considered during the claim and review process. Your failure to file suit within this time limit results in the loss/waiver of your right to file suit.

Neither the participant nor any beneficiary or other individual may file a civil action in federal court to recover benefits under the Plan or to enforce or clarify his or her rights under Section 502 or Section 510 of ERISA, or any other provision of law, whether or not statutory, until the claim and mandatory internal review procedures in this section have been exhausted in their entirety.

COORDINATION OF BENEFITS (COB)

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

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

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

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

COB DEFINITIONS

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

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

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

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

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

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

Aflac
PPO Plan

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

The following are non Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, pre-certification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary high-Deductible health plan’s Deductible, if the Claims Administrator has been advised by you that all Plans covering you are high-Deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
7. Any amounts incurred or claims made under the Prescription Drug program of This Plan.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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

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

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

1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

   If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to calendar years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - The Plan covering the Custodial parent;
     - The Plan covering the Spouse of the Custodial parent;
     - The Plan covering the non-custodial parent; and then
     - The Plan covering the Spouse of the non-custodial parent.
3. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1 above will determine the order of benefits as if those individuals were the parents of the child.

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

Rule 4 - COBRA. If you are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering you as an Employee, Member, Subscriber or retiree or covering you as a Dependent of an Employee, Member, Subscriber or retiree is the Primary Plan and the COBRA or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if

"Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as an Employee or as a retired Employee and is covered under his or her own Plan as an Employee, Member, Subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as a Dependent of an Employee, Member or Subscriber or retired Employee and is covered under the other plan as a Dependent of an Employee, Member, Subscriber or retiree).

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

When an Employee, Retiree or Covered Dependent is covered under two or more Plans which together pay more than this Plan's benefits, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable by this Plan will be reduced by the combined benefits of all other Plans covering you or your Dependent.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. The Plan has paid or for whom the Plan have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

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

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Members with active current employment status who are eligible for Medicare based on age or disability, including those Members age 65 or older, and their Spouses and Eligible Dependents, including those Spouses age 65 or older; and
- Individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

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

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

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source.

Recovery
A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation
The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- The Plan has the right to take whatever legal action it sees fit against any person, 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 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, attorney liens, other expenses or costs you incur. 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.

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 in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan’s rights will not be reduced due to your negligence.

- You and your legal representative 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) to be paid to the Plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.

- Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.

- 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 the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.

- 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 you or make you whole.

Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan.

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- You must not do anything to prejudice the Plan's rights.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

GENERAL INFORMATION

Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator or your Employer is authorized to change the form or content of this Benefit Booklet. Such changes can be made by the Plan Administrator.

Circumstances Beyond the Control of the Plan

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

Protected Health Information under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. 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's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. Please refer to the Notice of Privacy Practices in the Aflac Benefits Guide. If you would like a copy of Anthem's Notice, contact the Member Services number on your Identification Card.

Worker's Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Employees or Covered Dependents are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to an Employee or Covered Dependent shall be reimbursed by, or on behalf of, the Employee or Covered Dependent to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation or equivalent Employer liability or indemnification law.

Other Government Programs

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

Medicare Program

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

- **If You Are Under Age 65 With End Stage Renal Disease (ESRD)**
  If you are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Booklet before Medicare benefits for a limited period of time. This includes the Medicare "three month waiting period" and the additional 30 months after the Medicare Effective Date. After 33 months, the benefits described in this Benefit Booklet will be reduced by the amount that Medicare allows for the same Covered Services.

- **If You Are Under Age 65 With Other Disability**
  If you are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Booklet before Medicare benefits. This is the case **only** if you are actively employed by Aflac or the enrolled Spouse, Domestic Partner or child of the actively employed Employee. If you and your family are enrolled in the Retiree coverage offered under the Plan, you and your family members will lose eligibility for coverage under the Plan once you become eligible for Medicare due to disability. Spouses and Domestic Partners of Retirees will also be ineligible for coverage under the Plan if they become eligible for Medicare due to disability before the Retiree is Medicare eligible. If the covered child of a Retiree becomes eligible for Medicare due to disability, the child will remain eligible for coverage under the Plan, but the Plan will pay secondary to Medicare.

- **If You Are Age 65 or Older**
  If you are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Booklet before Medicare. This is the case **only** if you are actively employed by Aflac or the enrolled Spouse, Domestic Partner or child of the actively employed Employee. If you and your family are enrolled in the Retiree coverage offered under the Plan, you and your family members will lose eligibility for coverage under the Plan once you become eligible for Medicare due to age. Spouses and Domestic Partners of Retirees will also be ineligible for coverage under the Plan if they become eligible for Medicare due to age before the Retiree is Medicare eligible.

If you do not enroll in Medicare Part B when you are eligible, and the Plan is permitted under Federal law to pay secondary to Medicare (for example, you are a retiree or a COBRA participant), you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Right of Recovery and Adjustment

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

Modifications or Changes in Coverage, Termination

The Employer may amend, modify, or terminate this Plan or any benefit program provided under the Plan at any time in any manner or with respect to any individual, including but not limited to employees, Eligible Dependents, Retirees, and disabled individuals, in its sole discretion. The Employer reserves the right to modify the Plan to provide different cost sharing between the Employer and participants, at any time. Any amendment adopted will be in writing and executed by the individual so authorized by the Employer. Coverage upon Plan termination will be governed by the terms of the Plan. If the Plan is terminated, the rights of Members are limited to Covered Services incurred before the Plan's termination. In connection with the termination, the Plan Administrator may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Services incurred prior to the termination date and submitted in accordance with the rules established by the Plan Administrator.

Fraud

Knowingly and willfully engaging in fraudulent behavior, including executing, or attempting to execute, a scheme to defraud the Plan, or to obtain by means of false or fraudulent pretenses, any of the money or property owned by or under the control of the Plan, by you or your Eligible Dependents, may result in immediate termination from coverage under the Plan. Additionally, if you or your Eligible Dependents knowingly and willfully falsify,

conceal, or cover up any material fact, or make any materially false, fictitious, or fraudulent statements in connection with enrollment in the Plan, or the receipt of health care benefits under the Plan, coverage under the Plan may be immediately terminated.

Examples of fraudulent behavior include, but are not limited to, knowingly and intentionally:

- Filing Claims containing incomplete or misleading information,
- Misrepresenting the eligibility of a dependent or other person for coverage,
- Using or permitting someone else to use an identification card for unauthorized purposes, or
- Any other conduct which defrauds or deceives the Plan.

The Plan Administrator has the right to seek full recovery of any losses from, and to pursue criminal and civil prosecution against any individuals committing fraudulent behavior.

Errors

An error cannot give a benefit to you if you are not actually entitled to the benefit.

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and federal law.

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

Policies and Procedures

The Claims Administrator, 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.

The Claims Administrator has the authority, in its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Plan, unless otherwise agreed to by the Employer. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice.

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits. As such, program features are not guaranteed under the Plan and could be discontinued at

any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Waiver

No agent or other person, except an authorized employee of the Employer with authority to act on behalf of the Plan, 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.

Reservation of Discretionary Authority

The Plan Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the plan document and this Benefit Booklet. This includes, without limitation, the power to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the plan document and this Benefit Booklet. The Plan Administrator has delegated its fiduciary duties with respect to initial claim and final internal appeal determinations under the Plan to the Claims Administrator. The Claims Administrator has the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to it, including full discretionary authority to interpret the Plan; determine eligibility for and the amount of benefits under the Plan; and exercise all of the power and authority contemplated by ERISA with respect to making initial claim and final internal appeal determinations under the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet in its role as the Claims Administrator. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including the Claims Administrator's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Payment Innovation Programs

The Claims Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Claims Administrator under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance

amounts related to payments made by or to the Claims Administrator under the Program(s), and you do not share in any payments made by Network Providers to the Claims Administrator under the Program(s).

Care Received Outside the United States

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

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

Confidentiality and Release of Information

Applicable state and Federal law requires the Claims Administrator to undertake efforts to safeguard your medical information.

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

WHEN COVERAGE TERMINATES

When Coverage Ends

An Employee's participation in the Plan will end under the following conditions:

- You terminate employment or you are no longer classified by the Company as a regular, full-time employee working at least 30 hours per week (unless you are an ACA Eligible Employee). Your participation ends on the date you terminate employment or change to ineligible status (unless you are eligible to continue benefits during your severance period, if any).
- You do not return to employment after your Aflac approved leave of absence. Your participation ends on the date you should have returned to employment with Aflac.
- You are laid off by Aflac. Your participation will end according to the current practice applicable to your employment classification.
- You cancel your participation in the Plan during an Annual Enrollment Period. Your participation in will end on the last day of the current Plan Year.
- You cancel your coverage under the Plan after a Qualified Status Change Event. Your participation will end as of the last day of the month following the Qualified Status Change Event.
- You stop making Benefit Contributions. Your participation in the Plan will end on the last day for which you have made Benefit Contributions.
- Aflac terminates the Plan. Your participation will end on the effective date of any Plan termination.

ACA Eligible Employees and their dependents' coverage will end under the Plan on the last day of the Applicable Stability Period if the ACA Eligible Employee was not a full-time employee during the Applicable Measurement Period.

A Retiree's coverage under the Plan will end as follow:

- The earliest of the date your contributions cease;
- The date you are no longer eligible to participate in this Plan;
- The date you reach age 65;
- The date you become eligible for another employer's health plan (regardless of whether you actually enroll in the other employer's plan);
- The date you become eligible for Medicare benefits due to age or disability; or
- The date Aflac terminates the Plan or the Retiree medical benefit program.

An Eligible Dependent's coverage under the Plan will end as follows:

- on the date the Employee's/Retiree's coverage under the Plan terminates;
- on the first day the dependent is no longer an Eligible Dependent (your child will continue to be an Eligible Dependent, if all other criteria are met, until the end of the month in which your child turns age 26);
- on the date of a change in coverage due to a Qualified Status Change Event and your timely notice of it;

- for an Eligible Dependent who is covered by the Plan under the terms of a Qualified Medical Child Support Order, on the date coverage ends according to the terms of the Qualified Medical Child Support Order, if coverage may be dropped under the Plan's Qualified Status Change Event rules and the Employee elects to drop coverage;
- for a Spouse or Domestic Partner covered under the Retiree portion of the Plan, on the date the Spouse or Domestic Partner becomes eligible for another employer's health plan (regardless of whether the Spouse or Domestic Partner actually enrolls in the other employer's plan);
- for a Spouse or Domestic Partner covered under the Retiree portion of the Plan, on the date the Spouse or Domestic Partner becomes eligible for Medicare due to age or disability; or
- on the date that the Plan is terminated or amended to exclude the Eligible Dependent from coverage; coverage will end on the effective date of the termination or amendment.

Please Note: Retirees who voluntarily drop their coverage, or whose coverage is canceled due to their failure to timely pay benefit contributions, are not permitted to re-enroll in the Plan. If addition, if a Retiree or his or her Spouse or Domestic Partner becomes ineligible for the Plan due to other health coverage, the individual will not be permitted to re-enroll in the Plan, even if that other coverage is later lost.

Continuation of Coverage (Federal Law-COBRA)

Under certain circumstances you or your Eligible Dependents covered by the Plan ("**Covered Dependents**") have the right, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("**COBRA**"), to continue coverage under the Plan ("**COBRA Continuation Coverage**" or "**Continuation Coverage**"). COBRA Continuation Coverage is available to you and to Covered Dependents when you or they would otherwise lose group health coverage under the Plan. This section generally explains COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. Aflac has engaged a COBRA Administrator to assist with its COBRA obligations ("**COBRA Administrator**"). You may contact the Employee Benefits Department to obtain the contact information for the COBRA Administrator.

Please Note: You may have other options available to you when you lose Plan coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Qualifying Events

COBRA Continuation Coverage is available if you are enrolled in the Plan and you and your Covered Dependent's enrollment would otherwise end on account of a "**Qualifying Event**" COBRA Continuation Coverage is offered to each person who is a Qualified Beneficiary. A "**Qualified Beneficiary**" is someone (other than a Domestic Partner) who will lose coverage under the Plan because of a Qualifying Event. You, your legal spouse and your children could become Qualified Beneficiaries if coverage under the Plan is lost as a result of the Qualifying Event. Continuation coverage will also be offered to your registered Domestic Partner if his or her coverage under the Plan is lost because of a Qualifying Event on the same basis that coverage would be provided to a spouse, even though your Domestic Partner is not considered a Qualified Beneficiary under COBRA.

You will become a Qualified Beneficiary if you will lose your coverage under the Plan because either of the following Qualifying Events occurs:

- your hours of work are reduced; or
- your employment ends for any reason other than your gross misconduct.

Your Covered Dependent Spouse and/or Covered Dependent Child will become a Qualified Beneficiary if coverage under the Medical Program will be lost because any of the following Qualifying Events occur:

- your death;
- your hours of employment are reduced;
- your employment ends for any reason other than your gross misconduct;
- you become entitled to Medicare benefits (under Part A, Part B, or both) and you lose your coverage under the Plan;
- you become divorced or legally separated from your Spouse; or
- your child stops being eligible for coverage under the Plan as an Eligible Dependent. (For this Qualifying Event, only the Covered Dependent child becomes a Qualified Beneficiary.)

Filing a proceeding in bankruptcy under Title 11 of the United States Code can sometimes be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Aflac, and that bankruptcy results in the loss of coverage for any Retiree covered under the Plan, the Retiree will become a Qualified Beneficiary with respect to the bankruptcy. The Retiree's legal spouse and dependent children will also be offered Continuation Coverage if bankruptcy results in the loss of their coverage under the Plan.

The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the Employee Benefits Department has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of your employment or a reduction of your hours of employment, or your death, Aflac will notify the COBRA Administrator of the Qualifying Event within 30 days of any of these events. For the other Qualifying Events (divorce or legal separation or a dependent Child's loss of eligibility for coverage as an Eligible Dependent or your entitlement to Medicare benefits), you or a Qualified Beneficiary with respect to the Qualifying Event, or a person acting on your or his or her behalf, must notify the Employee Benefits Department in writing **within 60 days after the latest of:**

- the date of the Qualifying Event; or

- the date on which you or a Covered Dependent loses (or would lose) coverage under the Plan.

After the Employee Benefits Department receives notice relating to a Qualifying Event, if it is determined that you or your Covered Dependents do not qualify for such coverage, you or they will be provided written notice within a reasonable period of time explaining why COBRA Continuation Coverage is unavailable.

If you, a Qualified Beneficiary, or a person acting on your or his or her behalf, do not provide the notice to the Employee Benefits Department within the time limit explained above, coverage under the Plan cannot be continued.

After a Qualifying Event has occurred and proper notice of the event has been provided, you and your Covered Dependents will be notified by the COBRA Administrator about your/their right to COBRA Continuation Coverage. The COBRA Administrator, on behalf of the Plan Administrator, has 44 days from the later of the date of the loss of coverage or the Qualifying Event, to provide you and your family members with a notice of your right to elect COBRA Continuation Coverage ("**COBRA Election Notice**").

Electing COBRA Continuation Coverage

If it is determined that you and each of your Covered Dependents qualify for COBRA Continuation Coverage, each of you may individually decide whether or not to continue coverage. You and each of your Covered Dependents will have the right to elect the same coverage under the Plan in which you were enrolled immediately before the Qualifying Event. Both you and your Spouse may elect COBRA Continuation Coverage, or only one of you may choose it. Spouses may elect coverage for each other and parents may elect to Continue Coverage on behalf of their Covered Dependent Children. **If you or a Covered Dependent wants to elect Continuation Coverage, you must do so within 60 days of the date the notice of your right to elect COBRA Continuation Coverage was sent by the COBRA Administrator.**

As long as you elected and you are covered by COBRA Continuation Coverage during the Plan's Annual Enrollment Period, you may make changes to your Plan elections during the Annual Enrollment Period, including adding new coverage or changing your options under the Plan.

You should take into account that you have a special enrollment period for another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the Qualifying Events listed above. This other coverage may cost less than COBRA Continuation Coverage. You will also have the same special enrollment right at the end of the Continuation Coverage if you get Continuation Coverage for the maximum time available to you.

Premium Payments
COBRA Continuation Coverage is at your expense or your Covered Dependent's expense. The monthly cost of COBRA Continuation Coverage will be included in the election notice sent to you. The amount you must pay for COBRA Continuation Coverage will not exceed 102 percent of the cost for this coverage to the Plan (including both Aflac's and your contributions) for a similarly situated participant or beneficiary who is not receiving COBRA Continuation Coverage (or in the case of an extension of COBRA Continuation Coverage due to a disability, as explained below, 150 percent of that cost). You will have to pay COBRA premiums on an after-tax basis.

For coverage to continue, the first premium must be received by the date stated in the election notice sent to you. Normally, this date will be 45 days after COBRA Continuation Coverage is elected. Premiums for every following month of Continuation Coverage must be paid monthly on or before the premium due date stated in the notice sent to you. There is a 30-day grace period for these monthly premiums. If they are not paid within 30 days after their due date, COBRA Continuation Coverage will end as of the first day of that period of coverage and cannot be reinstated. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and, if the shortfall is not paid within 30 days of the date the notice is received, COBRA Continuation Coverage will end as of the first day of that monthly period of coverage.

Duration of Coverage
COBRA Continuation Coverage for you and/or your Covered Dependents will start on the date of the loss of coverage may continue until the earliest of the following:

Qualifying Event	Maximum Period of COBRA Continuation Coverage
Your termination of employment and/or reduction in hours of employment	18 months
You or your Covered Dependent qualify for a disability extension	29 months
Your divorce, legal separation, death or becoming entitled to (enrolled in) Medicare benefits	36 months
Your Covered Dependent Child's loss of dependent status	36 months

However, your or your Covered Dependent's COBRA Continuation Coverage period may be terminated before the maximum period of coverage to which you were entitled if one of the following events occur. In this case, your coverage will end on:

- The date of any coverage period for which a premium payment was due but not paid.

- The date after the Qualified Beneficiary first becomes covered under another employer's Group Health Plan; provided the Qualified Beneficiary becomes covered after his or her election of COBRA Continuation Coverage.

- The date the Qualified Beneficiary first becomes entitled to (enrolled in) Medicare benefits (under Part A or Part B, or both); provided the Qualified Beneficiary becomes enrolled in Medicare benefits after his or her election of COBRA Continuation Coverage.

- The date Aflac terminates all of its group health plans.

If you or a Covered Dependent's COBRA Continuation Coverage is terminated for any reason before the maximum period of coverage to which you were entitled, you or your Covered Dependent will be notified of that fact and provided with an explanation of why Continuation Coverage was terminated.

Newborns and Adopted Children
If you or your Spouse elect COBRA Continuation Coverage, any Child born to or adopted by you and your Spouse during the period of Continuation Coverage will also be a Qualified Beneficiary, and be entitled to Continuation Coverage for the maximum period of coverage available to any family member, as long as you notify the COBRA Administrator within 31 days of the birth or adoption.

Second Qualifying Event
If COBRA Continuation Coverage was elected by a Covered Dependent because your employment ended or your hours were reduced (including COBRA Continuation Coverage during a disability extension period) and if, during the period of Continuation Coverage, another Qualifying Event occurs, the maximum period of Continuation Coverage for the Covered Dependent is extended, upon proper notice to the COBRA Administrator, for up to an additional 18 months (that means, to a maximum of 36 months from the date your coverage ended or your hours were reduced). This extension may be available to your Covered Dependents receiving COBRA Continuation Coverage in the event of your death or divorce, or if your dependent child stops being an Eligible Dependent under the Plan, but only if the event would have caused the Covered Dependent to lose coverage under the Plan had the first Qualifying Event not occurred. The extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours. Continuation Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.

You or the Covered Dependent, or a person acting on your or his or her behalf, must notify the COBRA Administrator **in writing within 60 days after the latest of**:

- the date of the second Qualifying Event; or

- the date on which the Covered Dependent would lose coverage under the Plan as a result of the second Qualifying Event.

If you or the Covered Dependent, or a person acting on your or his or her behalf, do not provide the notice to the COBRA Administrator within the time limit explained above, the maximum period for Continuation Coverage will not be extended beyond the original 18-month coverage period.

Medicare-Eligible Employees
If you become entitled to (enrolled in) Medicare (Part A or B) while you are still employed by Aflac and you then lose your health coverage because of a Qualifying Event that is a termination or reduction in your hours of employment, you can elect to have both COBRA Continuation Coverage and Medicare coverage at the same time. It may be more beneficial to purchase a Medicare supplemental contract instead of COBRA Continuation Coverage. After the Qualifying Event, your COBRA Continuation Coverage will be secondary to Medicare with respect to services or supplies that are covered, or would be covered upon proper application, under Parts A or B of Medicare.

If you think you will need both Medicare and COBRA after your retirement, you should enroll in Medicare *on or before* the date on which you elect COBRA Continuation Coverage. If you do not enroll in Medicare *on or before* the date on which you elect COBRA Continuation Coverage, your COBRA benefits will end when your Medicare coverage begins. Your Covered Dependents, however, will remain eligible for COBRA Continuation Coverage.

Covered Dependents of Medicare-Eligible Employees
If you become entitled to (enrolled in) Medicare (Part A or B) while you are still employed by Aflac (but no more than 18 months before the Qualifying Event) and you then lose your health coverage because of a Qualifying Event that is a termination or reduction in your hours of employment, then your Covered Dependents may elect COBRA Continuation Coverage for the balance of the 36-month period starting when you became entitled to Medicare, or 18 months from your later termination or reduction in hours of employment, whichever period is longer.

You or your Covered Dependents, or a person acting on your or their behalf must provide notice of your entitlement to Medicare benefits (under Part A, Part B or both) at the time you elect COBRA Continuation Coverage.

Disabled Individuals
When the Qualifying Event for COBRA Continuation Coverage is your termination of employment or the reduction in your hours of employment, the 18-month period of COBRA Continuation Coverage is extended by an additional 11 months (to a total of 29 months) if these two conditions are met:

- The Social Security Administration determines that a Qualified Beneficiary (you or a Covered Dependent) is disabled, and that the date the Qualified Beneficiary's disability began was either:
  - within the first 60 days of Continuation Coverage (in the case of a child born to or placed for adoption with you and your Spouse, the 60-day period is measured from the date of birth or placement for adoption); or
  - before the Qualifying Event and the Social Security Administration considers that the Qualifying Beneficiary remains disabled as of the date of the Qualifying Event.

- You or a Covered Dependent, or a person acting on your or his or her behalf, provide written notice to the COBRA Administrator of the Social Security Administration's disability determination before the end of the original 18-month period of Continuation Coverage and **within 60 days** after the latest of:
  - the date of the disability determination by the Social Security Administration;
  - the date on which the Qualifying Event occurred; or
  - the date on which you or a Covered Dependent loses (or would lose) coverage under the Plan as a result of the Qualifying Event.

If you or a Covered Dependent, or a person acting on your or his or her behalf, do not provide the notice to the COBRA Administrator within the time limit explained above, the maximum period for Continuation Coverage will not be extended beyond the original 18-month coverage period.

Continuation Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc. You, a Covered Dependent, or another person acting on your or his or her behalf, must notify the COBRA Administrator within 30 days of the date you are finally determined not to be disabled under the Social Security Act, if such a determination is made.

The 11-month disability extension of COBRA Continuation Coverage will end on the first day of the month following the date the Qualified Beneficiary is determined not to be disabled. Continuation Coverage due to the

initial employment-related Qualifying Event, or any subsequent Qualifying Event, may still be available if the maximum period for such Continuation Coverage has not expired as of the date a determination of "no longer disabled" is made.

Form and Manner of Notice to the Employee Benefits Department and COBRA Administrator
Any notice to the Employee Benefits Department or to the COBRA Administrator will need to be in writing and must include:

- the name of the employee or former employee who is or was a Plan participant;
- a description of the Qualifying Event (and second Qualifying Event, if any);
- the date of the Qualifying Event (and second Qualifying Event, if any); and
- the name(s), address(es) and Social Security number(s) of the employee and/or Covered Dependents involved in the Qualifying Event; and
- for a disabled individual, a copy of the Social Security Administration disability determination and the date of the determination.

The timely provision of the notice by one individual will satisfy the notice requirement on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Questions About COBRA Continuation Coverage
If you are an active participant in the Plan or a COBRA participant and you have questions about COBRA Continuation Coverage, you may contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration in your area or visit its website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District Employee Benefits Security Administration offices are available through its website.

Keep the Plan Informed of Address Changes
In order to protect your family's rights, you should keep your COBRA Administrator, HR Representative, and the Benefits Department informed of any changes in the addresses of family members. You should also keep copies, for your records, of any notices you send to the COBRA Administrator or the Benefits Department.

MILITARY LEAVE CONTINUATION COVERAGE
If you take a military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("**USERRA**"), you have the right to elect up to 24 months of continuation coverage for you and your Covered Dependents under the Plan. You may elect continuation coverage for your Eligible Dependents who are participants in the Plan immediately before the date of your qualified military leave of absence under USERRA as well.

If you do not wish to receive some or all of the coverage during your military leave that you were receiving just prior to your leave, you must inform the Employee Benefits Department before the start of your leave. Benefits under the Plan will terminate on the date you start your leave of absence.

If you elect continuation coverage under USERRA, the cost of coverage during the first 30 days of your leave will be the amount charged to active employees for the same coverage. If your leave continues beyond 30 days, then the cost of your coverage for the remainder of the 24-month period may be increased up to 102 percent of the total cost of coverage under the Plan (which includes your share of the cost of coverage and any portion previously paid by Aflac plus a two percent administrative fee).

Your monthly payment must be sent to the COBRA Administrator. If you do not make your required Benefit Contributions, your participation will end on the last day of the coverage period for which you have made Benefit Contributions.

Under federal law, the period of coverage available to you and your Covered Dependents under USERRA runs concurrently with any continuation coverage available under COBRA. Eligibility for TRICARE or active duty military coverage will not terminate USERRA continuation coverage.

COBRA Coverage for Retirees

Retirees are Qualified Beneficiaries with respect to active Employee coverage under the Plan when their active employment with Aflac terminates. If you elect to receive retiree coverage under this Plan and decline COBRA, you will not also be eligible for COBRA Continuation Coverage as a result of your termination of employment. You will not be offered COBRA Continuation Coverage when you become entitled to Medicare benefits and lose your coverage under this Plan.

If you are the Spouse of a Retiree you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your other Covered Dependents will also be Qualified Beneficiaries in case of these events, if their coverage under the Plan ends due to the event, or if they stop being eligible under the Plan as an Eligible Dependent.

DEFINITIONS

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

Actively at Work
Actively at Work means performing all of the regular duties of the Employee's occupation at one of the following: at one of the Employer's regular places of business; at such location designated by the Employer, including without limitation the Employee's residence, at which the Employee has the ability to perform all of the regular duties of his/her occupation based on the availability of the equipment and/or materials needed by the Employee to perform such duties; or at some location to which the Employer's business requires the Employee to travel to perform his/her regular duties or other duties assigned by the Employer. An Employee is also considered to be actively at work on each day of regular paid vacation or non-working day, but only if the Employee is performing in the customary manner all of the regular duties of his/her occupation with the Employer on the immediately preceding regularly scheduled work day. Actively at work also means any approved leave of absence by Aflac including the Family Medical Leave Act of 1993 (FMLA), temporary lay-off and disability, for not more than 180 days. For purposes of this Plan, disability shall mean incapacity resulting from illness or injury which prevents the Employee from performing the material and substantial duties of his/her occupation.

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

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

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

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

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

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

Substance Abuse Residential Treatment which is specialized 24 hour care that occurs in a licensed Residential Treatment Center (RTC) or intermediate care facility. It offers individualized and intensive treatment in a residential setting and includes:

- observation and assessment by a psychiatrist weekly or more frequently
- an individualized program of rehabilitation, therapy, education, and recreational or social activities in compliance with existing law

Residential treatment provides an intermediate-term approach to treatment that attempts to return the patient to the community.

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

Benefit Period

One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a covered person's Effective Date. It does not continue after a covered person's coverage ends.

Centers of Excellence (COE) Network

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

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

Claims Administrator

The company the Plan Administrator chose to administer benefits under the Plan. Anthem Insurance Companies, Inc. was chosen to administer this Plan. The Claims Administrator provides administrative claims payment and review services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the Schedule of Benefits for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments

Combined Limit

The maximum total of Network and Out-of-network benefits available for designated health service in the Schedule of Benefits.

Complications of Pregnancy

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

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

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

Congenital Anomaly

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

Coordination of Benefits

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

Copayment

A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the Schedule of Benefits for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the provider when services are rendered.

Cosmetic Surgery

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

Covered Dependent

Any Dependent in an Employee or Retiree's family who meets all the requirements of the Eligibility section of this Benefit Booklet, and has enrolled in the Plan.

Covered Services

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

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions performed by a Center of Excellence or Network Transplant Provider as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement.

Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

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

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

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

Domestic Partner
For the purposes of this Plan, a Domestic Partner means the same or opposite gender domestic partner of the Employee or Retiree with whom the Employee/Retiree has registered under a domestic partnership law. Registration may be in any jurisdiction that legally allows domestic partnerships. Documentation of the registration must be provided to the Aflac Employee Benefits Department. Employees/Retirees seeking coverage for a Domestic Partner cannot be legally married. **Note:** Eligibility for a Retiree's Domestic Partner under the Retiree medical benefit program offered under the Plan ends once the Domestic Partner is eligible for (i) Medicare due to age or disability, or (ii) another employer's health plan.

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

Effective Date
The date for which the Plan approves an individual application for coverage.

Elective Surgical Procedure
A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Eligible Dependent
The covered Employee's legal spouse, registered domestic partner, the biological children of employees, the biological children of registered domestic partners, and the stepchildren of employees; adopted children and children placed in an employee's home for adoption before reaching age 18; and children for whom an

employee is appointed as legal guardian. Eligible Dependent children are eligible for coverage under the Plan until age 26, except that mentally or physically disabled children remain covered no matter what age. You must give the Benefits Department evidence of your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Benefits Department. This proof of incapacity may be required annually by the Plan. **Note:** Eligibility for a Retiree's legal spouse or registered domestic partner under the Retiree medical benefit program offered under the Plan ends once the spouse or domestic partner becomes eligible for (i) Medicare due to age or disability, or (ii) another employer's health plan.

Employee

A person who is a regular, full-time Employee of the Employer who is Actively at Work a minimum of 30 hours per week or who is eligible under the Employer's policies for determining full-time status under the Affordable Care Act.

Employer

Aflac Incorporated.

Experimental or Investigational

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator determines to be unproven.

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

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

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

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

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

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Facility

A Facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this Benefit Booklet. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

Freestanding Ambulatory Facility

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

Group Health Plan

An Employee Welfare Benefit Plan (as defined in Section 3(1) of ERISA) established by the Employer.

Home Health Care

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

Home Health Care Agency

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

Hospice

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

Hospice Care Program

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

Hospital

An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or disabled children.

Identification Card

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

Illness

Any bodily sickness, disease or mental/nervous disorder. A mental/nervous disorder means any diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorder (DSM, most recent edition, revised), except as specified in Limitations and Exclusions, for which treatment is commonly sought from a psychiatrist or mental health provider. The DSM is a clinical diagnostic tool developed by the American Psychiatric Association and used by mental health professionals. Diagnoses described in the DSM will be considered mental/nervous in nature, regardless of etiology.

Ineligible Charges

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

Ineligible Provider

A provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a provider are not eligible for payment.

Infertile or Infertility

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

Injury

Bodily harm from a non-occupational accident.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

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

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

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

Medical Emergency
"Emergency services," "emergency care," or "Medical Emergency" means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be Medical Emergencies by the Plan.

Medical Necessity (Medically Necessary)
Procedures, supplies, equipment, or services that the Claims Administrator concludes are:

1. Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
2. Given for the diagnosis or direct care and treatment of the medical condition; and
3. Within the standards of good medical practice within the organized medical community; and
4. Not mainly for the convenience of the Doctor or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, or service must meet the following requirements:

1. There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and
2. Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and
3. For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of your illness, Injury or disease, the service is: (1) not more costly than another service or group of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed

on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

Network Provider

A Provider, including but not limited to a Hospital, Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies that has a contract with the Claims Administrator to provide Covered Services to Members. A Network Provider for one plan may not be a Network Provider for another. Please see "How to Find a Provider in the Network" in the section entitled **"How Your Plan Works"** for more information on how to find a Network Provider for this Plan.

Non-Covered Services

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

Out-of-Network Provider

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

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

Out-of-Pocket Maximum

The maximum amount of a Member's Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services, exclusive of other scheduled charges**.**

Partial Hospitalization Program

Structured, multidisciplinary behavioral health 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. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Physical Therapy

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

Physician

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

Plan

The PPO Plan Medical Benefit Option offered under the Aflac Employee Health and Welfare Benefits Plan.

Plan Administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about plan details. The Plan Administrator is not the Claims Administrator.

Plan Sponsor

Aflac
PPO Plan

Aflac Incorporated. The Plan Sponsor is not the Claims Administrator.

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.

Retail Health Clinic
A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.

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

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

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

Specialist (Specialty Care Physician\Provider or SCP)
A Specialist is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Spouse
For the purposes of this Plan, "Spouse" means the one individual who is legally married to the Employee in accordance with the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, as determined pursuant to the Internal Revenue Code and ERISA. **Note:** Eligibility for a Retiree's Spouse under the Retiree medical benefit program offered under the Plan ends once the Spouse is eligible for (i) Medicare due to age or disability, or (ii) another employer's health plan.

Transplant Providers
Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to:

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

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association

Urgent Care

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

Utilization Review

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

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group Health Plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

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

Statement of Rights Under the Women's Cancer Rights Act of 1998

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

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

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

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

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your Spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your Employer or Plan Administrator to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and Out-of-Pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and Out-of-Pocket expenses applicable to other medical and surgical benefits.

STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each Member in an employee benefit plan. This information is outlined below.

- **Plan Name: Aflac Employee Health and Welfare Benefits Plan**

- **Plan Sponsor: Aflac Incorporated**
  1932 Wynnton Road
  Columbus, Georgia 31999

- **Plan Number: 501**

- **Employer I.D. Number: 58-1167100**

- **Type of Plan:** The Aflac Employee Health and Welfare Benefits Plan is an Employee welfare benefit plan providing group medical benefits as well as other health and welfare benefits. This Benefit Booklet describes the medical benefit program offered under the Aflac Employee Health and Welfare Benefits Plan, which is referred to throughout this Booklet as the "Plan."

- **Plan Year Ends:** December 31

- **Type of Administration/Funding:** Medical benefits furnished under the Plan are funded by Aflac Incorporated on a self-funded basis with claims being administered by Anthem Insurance Companies, Inc. (IN) on behalf of the Health Administrative Committee of Aflac Incorporated (the Plan Administrator).

- **Plan Administrator and Named Fiduciary: Health Administrative Committee of Aflac Incorporated**
  1932 Wynnton Road
  Columbus, Georgia 31999
  706-317-0770

- **Agent for Service of Legal Process: Aflac Incorporated**
  1932 Wynnton Road
  Columbus, Georgia 31999

  Service may also be made on the Plan Administrator.

- **Description of Benefits**
  This Benefit Booklet sets forth the benefits provided under the Plan. A brief explanation of these benefits may be found in the section entitled "**Schedule of Benefits**". A more detailed description of the benefits appears in the section entitled "**Benefits**".

- **Eligibility for Participation**
  The eligibility requirements for participation in this Plan are set forth in the section entitled "Eligibility".

- **Claims Procedures.**
  The section of this Benefit Booklet entitled "Claims Payment" contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Claims Administrator. Note that the Claims Administrator is not the Plan Administrator for the purposes of ERISA.

- **Review of Claim Denial**
  Please see the section of this Benefit Booklet entitled "Your Right to Appeal" for important information on how to appeal a denied claim, including important time limits that you must follow to preserve your right to appeal.

Limitation on Rights
The Plan does not constitute a contract between you and Aflac, nor is it to be consideration or inducement for your employment. Nothing contained in the Plan gives you the right to be retained in the service of Aflac or to interfere with the right of Aflac to discharge you at any time, with or without cause, regardless of the effect that the discharge will have upon you as a participant in the Plan.

Overpayments
An "**Overpayment**" occurs if the Plan pays an amount not payable under the Plan, if the Plan pays an expense or benefit more than once, or if an expense or benefit is paid by both the Plan and a third party. An expense or benefit is considered paid if it is paid to you or to someone else (for example, to a health care provider) on your behalf.

If an Overpayment is made by the Plan, the Plan has the right to recover the Overpayment. If that Overpayment is made to a health care provider, the Plan may request a refund of the Overpayment from either you or the provider. If the refund is not received from either you or the provider, the Overpayment will be deducted from future Plan benefits available to you or your Covered Dependents or from your wages, to the extent permitted by law, but the amounts withheld may not reduce your pay below the applicable state minimum wage law.

Enrollment Information
For purposes of the HIPAA Privacy and Security Rules, determining the employee's eligibility for the Plan or enrolling employees in the Plan is an enrollment function performed by Aflac. Employee and dependent eligibility and enrollment information is the Company's information and not the Plan's information while it is held and transmitted by Aflac.

Entire Representation

This document along with the formal plan document for the Plan are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral), including, but not limited to, severance agreements and employment agreements.

Acceptance and Cooperation

If you accept benefits under the Plan, you are considered to have accepted its terms, and you agree to perform any act and to execute any documents which may be necessary or desirable to carry out the terms of the Plan.

General Information About ERISA

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

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as 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.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 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. The Plan imposes strict deadlines for filing a lawsuit with respect to the Plan. Please see the "Your Right to Appeal" section of this Benefit Booklet for more information.

Claims Disclosure Notice

This Benefit Booklet contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Claims Administrator. In addition to this information, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below.

Urgent Care. The Plan must notify you, within 72 hours after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If your request for benefits does not contain all the necessary information, the Plan must notify you within 24 hours after receiving it and tell you what information is missing. Any notice to you by the Plan will be orally by telephone or in writing by facsimile or other fast means. You have at least 48 hours to give the Plan the additional information needed to process your request for benefits. You may give the Plan the additional information needed orally by telephone or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72 hours after the Plan's receipt of the request for benefits or 48 hours after receipt of all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The notice will explain the reason for the denial and the Plan provision upon which the decision is based. You have 180 days to appeal the decision. You may appeal the decision orally by telephone or in writing by facsimile or other fast means. Within 72 hours after the Plan receives your appeal, if your claim is still considered urgent under the circumstances at the time of the appeal, the Plan must notify you of the decision. The Plan will notify you orally by telephone or in writing by facsimile or other fast means. If your claim is no longer considered urgent, it will be handled in the same manner as a non-Urgent Care pre-service or post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The Plan must notify you, within 15 days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If the Plan needs more than 15 days to determine your benefits, due to reasons beyond its control, the Plan must notify you within that 15-day period that more time is needed to determine your benefits. But, in any case, even with an extension, the Plan cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your claim, the Plan must notify you, within 5 days after receiving it and tell you what information is missing. You have 45 days to provide the Plan with the information needed to process your request for benefits. The time period during which the Plan is waiting for receipt of the necessary information is not counted toward the time frame in which the Plan must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the denial within the time frame noted above after the Plan has all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The written notice will explain the reason for the denial and the Plan provisions upon which the decision was made. You have 180 days to appeal an adverse benefit determination. Your appeal must be in writing. Within 30 days after a pre-service appeal is received, the Plan must notify you of the decision. The notice of the decision will be in writing.

Concurrent Care Decisions. If, after approving a request for benefits in connection with your illness or Injury, the Plan decides to reduce or end the benefits that had been approved for you, in whole or in part:

- The Plan must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal the decision before the reduction in benefits or end of benefits occurs. In the notice to you, the Plan must explain the reason for reducing or ending your benefits and the Plan provisions upon which the decision was made.
- To keep the benefits you already have approved, you must successfully appeal the decision to reduce or end those benefits. You must make your appeal to the Plan at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal will be treated as if you were appealing a non-Urgent Care denial of benefits (see “Urgent Care” above).
- If your appeal for benefits is received at least 24 hours prior to the occurrence of the reduction or ending of benefits, the Plan must notify you of the decision regarding your appeal within 72 hours of the receipt of your appeal. If your appeal of the decision to reduce or end your benefits is denied, in whole or in part, the Plan must explain the reason for the denial of benefits and the Plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an Urgent Care denial of benefits (see “Urgent Care” above).

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Plan must notify you, within 30 days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If more than 30 days are needed to determine your benefits, due to reasons beyond the Plan's control, the Plan must notify you within that 30-day period that more time is needed to determine your benefits. But, in any case, even with an extension, the Plan cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for your claim, the Plan must notify you, within 30

days after receiving it and tell you what information is missing. You have 45 days to provide the information needed to process your claim. The time period during which the Plan is waiting for receipt of the necessary information is not counted toward the time frame in which the Plan must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above after the Plan has all the information needed to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the Plan provisions upon which the decision was made. You have 180 days to appeal the adverse benefit determination. Your appeal must be in writing. Within 60 days after receiving your appeal, the Plan must notify you of the decision. The notice to you of the decision will be in writing.

Note: Your, beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Plan and request a review of the adverse benefit determination. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed free of charge; and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

Medical information the Plan or the Claims Administrator has regarding your case will be released to you or an attorney only by written authorization from your provider and/or the Hospital.

- **Please Note: ERISA appeals will be administered by the Claims Administrator. Any appeals should be sent to Anthem Insurance Companies, Inc.**

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.