

Battelle Memorial Institute

PLAN/SUMMARY PLAN DESCRIPTION

Battelle Blue Cross Blue Shield Network Only Medical Plan for BMI Retirees Not Eligible for Medicare

January 1, 2010

Group Number: 003325000

TABLE OF CONTENTS

TABLE OF CONTENTS	2
INTRODUCTION	3
INTERPRETATION OF BENEFITS	5
SCHEDULE OF BENEFITS	8
DEFINITIONS	13
ELIGIBILITY, ENROLLMENT, TERMINATION, CONTINUATION AND CONVERSION	29
HOW TO OBTAIN COVERED SERVICES	40
HEALTH CARE MANAGEMENT	42
COVERED SERVICES	49
EXCLUSIONS	73
CLAIMS PAYMENT	78
GENERAL PROVISIONS	83
COMPLAINT AND APPEALS PROCEDURES	96
ERISA INFORMATION	102

INTRODUCTION

We are pleased to provide you with this legal Plan document and Summary Plan Description. This document describes your health benefits, as well as your rights and responsibilities, under the Plan.

The Plan is a self-insured health benefit plan intended to help pay for certain covered medical expenses for Participants and their enrolled Dependents. The Plan is called “self-insured” because Battelle Memorial Institute (“Battelle”), as opposed to an insurance company, assumes the risk for funding all benefits under the Plan. Contributions for Participants are held in the Battelle Employee Medical Benefits Trust until distributed, and are used exclusively for the benefit of such Participants and/or their Dependents for funding the Plan. The Battelle Employee Medical Benefits Trust is a “voluntary employees’ beneficiary association” under Internal Revenue Code Section 501(c)(9). Any funds contributed by Participants that are remaining in the trust upon the termination of the Plan and after all obligations are fulfilled shall be devoted to other employee benefits in accordance with the conditions of the Battelle Employee Medical Benefits Trust.

Battelle has contracted with Community Insurance Company (Anthem), an independent third party (the “Claims Administrator”) to process claims for the Plan according to the terms of the Plan document and industry standards. The Claims Administrator is not an insurer. Battelle is the Plan Administrator.

This Summary Plan Description has been prepared by the Plan Administrator, to help explain your health benefits. This document replaces and supersedes any summary plan description that you have received previously.

This document and any Riders, Amendments and attachments are intended to constitute the Plan document as required by Section 402 of the Employee Retirement Income Security Act of 1974 (“ERISA”) and the summary plan description as required by Section 102 of ERISA. Please refer to this document for information regarding benefits provided to Participants and their eligible Dependents under the Plan. This revised plan document is effective January 1, 2010.

Please refer to this Summary Plan Description whenever you require health services. It describes how to access medical care, what health services are covered by the Plan, and what portion of the health care costs you will be required to pay. This Summary Plan Description also contains exclusions, so please be sure to read this Summary Plan Description carefully.

This Summary Plan Description should be read and re-read in its entirety. Since many of the provisions of this Summary Plan Description are interrelated, you should read the entire Summary Plan Description to get a full understanding of your health benefits. You should call the Claims Administrator if you have questions about the limits or the coverage available to you.

Many words used in the Summary Plan Description have special meanings. These words appear in capital letters and are defined for you. Refer to these definitions in the *Definitions Section* of this Summary Plan Description for the best understanding of what is being stated.

Please be aware that your Physician does not have a copy of this document, and is not responsible for knowing or communicating your benefits to you.

INTERPRETATION OF BENEFITS

Participation in this Plan is voluntary and not a condition of employment. Participation is subject to the conditions specified in the Plan and such other conditions determined by the Plan Administrator to be necessary or desirable for the administration of the Plan.

The Plan Administrator and the Claims Administrator have sole and exclusive discretion to do all of the following:

- Interpret benefits under the Plan and to resolve all questions arising in the administration interpretation, and application of the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan.
- Make factual determinations related to the Plan and its benefits.

Benefits under this Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

The Plan Administrator or its delegate shall establish the Plan's policies, interpretations, practices and procedures. The Plan Administrator or its delegate has sole discretionary authority to determine eligibility for benefits, to construe and interpret the terms of the Plan, to decide disputes that may arise relative to a Covered Person's rights and to decide questions of Plan interpretation and those of fact relating to the Plan. The determinations and interpretations of the Plan Administrator or its delegate shall be conclusive and binding.

Upon challenge by a covered staff member, Dependent or other party, interpretations of Plan provisions, applications of the Plan to specific fact patterns and/or discretionary actions by the Plan Administrator and/or any other Plan fiduciaries shall be sustained unless the interpretation, application, or action in question was arbitrary and capricious.

The Plan Administrator and the Claims Administrator may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan may, in the sole discretion of the Plan Administrator or its delegate, offer benefits for services that would otherwise not be Covered Services. The fact that the Plan may do so in any particular case shall not in any way be deemed to require the Plan to do so in other similar cases.

Your Contribution to the Benefit Costs

Battelle and any participating employers fund all Benefits under the Plan, as well as the administrative costs to operate the Plan in accordance with its terms and the law. Battelle determines the amount, if any, it expects to contribute toward the cost of Participant health care under the Plan, based upon a flat dollar amount per Participant. The Battelle contribution (and if applicable any contribution by a participating employer) is referred to as Battelle's "subsidy". Battelle currently is applying the subsidy to the cost of coverage for a Participant and a Participant's Spouse. This is subject to change at any time. The cost of coverage for Enrolled Dependents other than Spouses is not subsidized.

Any costs over the amount of the Battelle subsidy are passed on to Participants. Battelle currently determines Participant contribution rates under the Plan annually prior to each calendar year and communicates contribution rates to members during the final quarter of the calendar year. Battelle reserves the right to raise and/or otherwise change contributions or any subsidy amount for coverage under the Plan or to cease coverage under the Plan entirely.

Subsidy Dependent Upon Years of Credited Service for New Participants after January 1, 2004

The amount of the subsidy (if any) is dependent upon Years of Credited Service for Participants hired by Battelle or a participating employer after December 31, 1993, and for Participants hired prior to December 31, 1993 who had not reached age 45 as of that date. Such Participants will receive a fraction of any subsidy, based upon the ratio of completed Years of Credited Service to 30, but no more than any total individual subsidy amount. For example, the amount of Battelle's subsidy for a Participant who retires with 10 Years of Credited Service would be 10/30 of any subsidy amount. A Participant with 30 or more Years of Credited Service would receive the full amount of any subsidy. As a result, premiums for Participants with fewer than 30 Years of Credited Service will be higher than Participants' with at least 30 Years of Credited Service.

Staff members who began employment on or after July 1, 2005 with Battelle Corporate Operations (BCO), Battelle Services Company, Inc (BSCI), Battelle National Biodefense Institute, LLC (BNBI), or Battelle Energy UK (BEUK), will not receive a subsidy (contribution) toward retiree medical benefits upon retirement.

Cost for Disabled Retirees

A Participant who is eligible for the Plan solely as a result of disability (i.e., prior to commencement of pension payment from a Battelle sponsored pension plan) is currently charged the same premium as a similarly situated active staff member with the same level of coverage. Battelle reserves the right to raise and/or otherwise change premiums for coverage under the Plan or to cease coverage under the Plan entirely, entirely within Battelle's discretion and without advance notice.

Payment of Plan Contributions

Premium payments are **due in advance of coverage on the first day of each month**. Your applicable premium payment will be deducted from your pension check provided that the monthly pension is sufficient to cover premiums. Alternatively, premium payments may be paid by personal check or money order, made payable to "Battelle." Send payments to: Huntington National Bank, Dept L1657, Columbus, Ohio 43260.

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Copayments and other limits when you receive Covered Services from a Provider. All Covered Services must be provided by a Network Provider, or approved as an Authorized Service. Please refer to the **Covered Services** section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Summary Plan Description including any attachments or riders. **This Schedule of Benefits lists the Covered Person's responsibility for Covered Services.**

Benefit Period	Calendar Year
Dependent Age Limit	Please see the Eligibility Section
Deductible	This Plan does not have an annual deductible
Out-of-Pocket Limit	
Per Person	\$1,000
Per Family	\$2,000

Note: The Out-of-Pocket Limit includes all flat dollar Copayments you incur for medical expenses, in a Benefit Period. Once the Covered Person and/or family Out-of-Pocket Limit is satisfied, no additional flat dollar Copayments will be required for the Covered Person and/or family for the remainder of the Benefit Period. Please note that the Out-of-Pocket Limit does not apply to retail or mail order drug purchases, co-pays and differentials for Brand Name Drug purchases when a Generic is available. You are always responsible for your share of Coinsurance and Copayments for these expenses.

**Lifetime Maximum for Medical Covered Services (excluding prescription drugs)
(includes amounts paid under any other Battelle sponsored self-insured plan)**

Per Person	\$2,000,000
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Covered Services**Copayment/Maximum****Preventive Care**

Covered in full after \$20 or \$30 Copay
(Copay determined by type of provider
seen)

Physician Office Services

\$20 per visit

Specialist Office Services

\$30 per visit

Inpatient Services

Covered in Full

Maximum days per Benefit Period for Physical
Medicine and Rehabilitation

60 days

Inpatient Facility Services

\$100 Copayment

Outpatient Facility Services

\$50 Outpatient Surgery Facility Copayment

Diagnostic Services

Covered in Full

Emergency Room Services

(If admitted directly from the Emergency Room,
the Emergency Room Copayment for that visit is
waived)

\$100 per visit

Urgent Care Center Services

\$50 per visit

Ambulance Services

Covered in Full

Therapy Services

(when rendered as Physician's Office Services or
Outpatient Facility Services)

\$30 per visit See Note Below

NOTE: If different types of Therapy Services are performed during one Physician Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the following applicable Maximum Visits. For example, if both a Physical Therapy Service and a Spinal Manipulation service are performed during one Physician Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Spinal Manipulation Visit.

Maximum Visits per Benefit Period for:

Physical Therapy 30 visits

Occupational Therapy 30 visits

Speech Therapy 20 visits

Spinal Manipulations 12 visits

Home Care Services Covered in Full

Hospice Services Covered in Full

Medical Supplies, Equipment and Appliances Covered in Full

NOTE: Physician office Copayments are applied rather than the Copayment listed above if medical supplies, Durable Medical Equipment or appliances are obtained in your Network Physician's office.

Maternity Services Covered in full after initial prenatal office visit Copayment and \$100 Copayment for hospital and delivery

Mental Health Services

Inpatient Services \$100 Copayment

Outpatient Services \$30 Office Visit Copayment; Other Settings are Covered in Full

Substance Abuse Services

Inpatient Services \$100 Copayment

Outpatient Services \$30 Office Visit Copayment; Other Settings are Covered in Full

Human Organ and Tissue Transplant Services

Covered in full for bone marrow, heart, lung, heart/lung, liver, pancreas, or kidney/pancreas transplant services for adults, if received at Blue Quality Centers for Excellence. Pediatric covered transplants include bone marrow, heart and liver. Kidney and cornea transplant services paid as any other service under medical. Contact Anthem Member Services at 800.514.3021 to locate a Blue Quality Center for Excellence.

Transportation and Lodging

Covered in Full

Prescription Drugs - Administered by CVS Caremark

Certain prescription benefits may require Prior Authorization or Specialty Guideline Management and/or have quantity limits that apply. Benefits are not available for all drugs, including medications that have an exact over-the-counter equivalent.

Retail Pharmacy (Network)	34 days
Mail Service	90 days
Specialty Drugs	30 days

Network Retail Pharmacy**Prescription Drug Copayment:**

Generic Drugs	\$10 Copayment
Brand Name Formulary Drugs	\$36 Copayment
Brand Name Non- Formulary Drugs	\$55 Copayment

Mail Service Program**Prescription Drug Copayment:**

Generic Drugs	\$20 Copayment
Brand Name Formulary Drugs	\$72 Copayment
Brand Name Non- Drugs	\$110 Copayment
Specialty Drugs	\$80 Copayment

Note: If you elect a Brand Name Drug when a Generic is available, you will be responsible for both your Copayment and the price difference between the Brand Name and the Generic Drug. Additionally, certain Diabetic supplies are covered in full.

Vision Services	Network Providers	Non-Network-Providers
Exam**		
BCO, BSCI, BNBI, BEUK	\$30 Copayment	Reimbursed up to \$35
PNNL	\$30 Copayment	Not Covered
Limited to one exam per Member every 12 months.		
Prescription Lenses		
Basic Lenses (Pair)		
Single Vision lenses	\$20 Copayment*	Reimbursed up to \$25
Bifocal lenses	\$20 Copayment*	Reimbursed up to \$40
Trifocal lenses	\$20 Copayment*	Reimbursed up to \$55
Progressive lenses	\$20 Copayment*, then covered up to bifocal amount	Reimbursed up to \$40
Lenticular lenses	\$20 Copayment	Reimbursed up to \$80
Limited to one pair of lenses per Member every 12 months.		
Frames	\$20 Copayment*; up to \$120 retail value	Reimbursed up to \$45
Contact Lenses – Elective	\$20 Copayment; up to \$105 retail value	Reimbursed up to \$105
Contact Lenses – Non –Elective (Medically Necessary)	Covered in Full	Reimbursed up to \$210

***If you purchase frames and Lenses, you will only pay one materials Copayment.**

**** Vision exams for BCO, BSCI, BNBI and BEUK retirees are covered under Anthem Blue Vision and vision exams for PNNL retirees are covered under the medical plan.**

Note: If you choose to utilize an offer, coupon or in-store advertisement for an in-network provider, you will have to submit your claim yourself and it will be paid as a non-network claim.

DEFINITIONS

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

Active Service – For purposes of the Plan, you are considered to be in “Active Service” with Battelle (including Battelle Corporate Operations (BCO) and Battelle Pacific Northwest Division (PNWD)), Battelle Services Company, Inc’s (BSCI), Battelle National Biodefense Institute, LLC’s (BNBI), or Battelle Energy UK (BEUK) on a day that is one of Battelle’s, BSCI’s, BNBI’s, or BEUK’s scheduled work days if on that day you are performing in the customary manner all of the regular duties of your employment with Battelle, BSCI, BNBI, or BEUK on a salaried basis either at one of Battelle’s, BSCI’s, BNBI’s, or BEUK’s business establishments or at some location to which Battelle’s, BSCI’s, BNBI’s, or BEUK’s business requires you to travel. You will be considered to be in Active Service on a day that is not one of Battelle’s, BSCI’s, BNBI’s, or BEUK’s scheduled work days only if you performed in the customary manner all of the regular duties of your salaried employment on the next preceding scheduled work day. Solely for purposes of determining eligibility, you are treated as being in Active Service if you are absent on account of an approved leave for disability, sickness or injury.

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

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

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level.

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

Brand Name Drug - The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer’s own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any pharmaceutical manufacturer can produce the drug and sell it under its own brand name, or under the drug’s chemical name (Generic).

Claims Administrator - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Claims Administrator is Community Insurance Company, but they may be referred to as Anthem. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance - If a Member's coverage is limited to a certain percentage, for example 85%, then the remaining 15% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

Concurrent Claim - A "Concurrent Claim" arises when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Plan participant requests extension of the course of treatment beyond that which the Plan has approved.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment - A specific dollar amount or percentage of Maximum Allowable Amounts for Covered Services indicated in the Schedule of Benefits for which you are responsible. Your flat dollar Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

Covered Person - A Participant or enrolled Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Employer and for whom Fee payment has been made. Covered Persons are sometimes called "you" or "your."

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

- Medically Necessary or otherwise specifically included as a benefit under this Summary Plan Description.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Summary Plan Description, or by any amendment or rider thereto.
- Authorized in advance by the Claims Administrator, if such Prior Authorization is required in this Summary Plan Description.

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

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by the Claims Administrator including necessary acquisition costs and preparatory myeloblastic therapy.

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

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

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

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

Dependent - includes your Spouse/Registered Partner (unless your Spouse/Registered Partner is also an eligible person) and your unmarried Dependent children. A Dependent child will be eligible for coverage under the Plan only until the end of the month in which he or she loses status as a Dependent under this Plan. A Dependent child will not be covered after the end of the month in which he or she reaches age 23, except as provided below for Disabled Dependents. A child may not be covered by more than one Participant for Plan purposes (e.g., for a child of married Participants). A Dependent child of the covered Participant is eligible if **all** of the following conditions apply:

- He or she is unmarried;
- He or she has not reached the age of 23;
- He or she permanently resides with the participant (full-time students with the participant's home address listed as their residence);
- He or she meets the requirements to be claimed as your Dependent for Federal income tax purposes (without regard to the income limitations); and
- One of the following conditions exist:
 - The child is the natural or adopted child of the Participant; or a child who permanently resides with the Participant in a parent-child relationship; or the child has been placed with you for adoption;
 - The Participant has legal guardianship of the child; or
 - The child is a stepchild of the Participant and also permanently resides in the Participant's household for the more than half of the year.
- A Dependent also includes a child for whom coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Plan Administrator is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

If the child does not meet the above conditions, he or she is not eligible for coverage.

Disabled Dependents – Your unmarried child who is 23 years of age or over and who is mentally or physically incapable of self-sustaining employment may qualify for continued Dependent coverage. In order to qualify, the Dependent must meet all requirements for a Dependent under the Plan other than age, and must be primarily dependent upon you for support. Medical proof of mental or physical incapacity satisfactory to the Claims Administrator and evidence that the Dependent is primarily dependent upon you for support, must be submitted to the Claims Administrator within 31 days of failure to qualify as a Dependent solely because of attainment of age 23. Your Dependent must have been covered under this Plan as your Dependent when he or she attained age 23, and the incapacity must have commenced before the Dependent reached age 23. Evidence of ongoing/continued incapacity and your primary support is required at least annually.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date your coverage begins under the Plan. A Dependent's coverage under the Plan begins on the Effective Date of the sponsoring Participant. No benefits are payable for services and supplies received before your Effective Date or after the end of the month in which your coverage terminates.

Elective Contact Lenses - All contact lenses that are not Non-Elective Contact Lenses:

Eligible Person – A former employee of Battelle (including BCO and PNWD), BSCI, BNBI, BEUK or a participating employer who, on the date of his termination for retirement, met all of the eligibility requirements as set forth in the Eligibility Requirements Section, or who meets all of the eligibility requirements for coverage for disability in the Eligibility Requirements Section.

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

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

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

Employer – The legal entity contracting with the Claims Administrator for administration of group health care benefits.

Experimental/Investigative - Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator or the Claims Administrator's designee determines in its sole discretion to be Experimental/Investigative. 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 conclusive 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;
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies;

- 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;
- documents of an IRB or other similar body performing substantially the same function;
- 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;
- medical records; or
- the opinions of consulting Providers and other experts in the field.

Family Coverage – Coverage provided by the Employer for the Participant and eligible Dependents.

Fee(s) - The periodic charges which are required to be paid by you and/or the Employer to maintain benefits under the Plan.

Formulary - Also called the Performance Drug List (PDL), is one or more list(s) of preferred pharmaceutical products, created and managed by Caremark, as amended from time to time, which: (1) has been approved by Caremark's Pharmacy and Therapeutics Committee, and (b) reflects Caremark's recommendations as to which pharmaceutical products should be given favorable considerations by plans and their participants.

Generic Drugs - Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug.

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

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

Lenses – Materials prescribed for the visual welfare of the patient. Materials would include single vision, bifocal, trifocal or other more complex lenses.

Lifetime Maximum - The maximum dollar amount for Covered Services paid by the Plan during your lifetime (includes amounts paid under any other Battelle sponsored self-insured plan).

Mail Order Pharmacy - An alternate method of obtaining maintenance or long term medications by mail if the Covered Person takes prescriptions on a regular basis. Mail Order Pharmacies are governed by Federal and State Laws to ensure safety and compliance as are retail pharmacies. Mail Order can be a reasonable, convenient, low-cost option in obtaining a 90 day supply of your maintenance medication, pending your drug program plan design.

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

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

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with the Claims Administrator, on behalf of the Employer, for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for the Plan.

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

Medically Necessary or Medical Necessity – An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Claims Administrator to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Covered Person's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;

- The most appropriate supply, setting or level of service that can safely be provided to the Covered Person and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention (“cost effective” does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Covered Person, the Covered Person’s family or the Provider; or
- Not otherwise subject to an exclusion under this Summary Plan Description.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Mental Health Conditions (including Substance Abuse) - A condition identified as a mental disorder in the most current version of the International Classification of Diseases, in the chapter titled “Mental Disorders.”

- **Mental Health** is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.
- **Substance Abuse** is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

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

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by the Claims Administrator, on behalf of the Employer, or with another organization which has an agreement with the Claims Administrator, on behalf of the Employer, to provide Covered Services and certain administrative functions to you for the network

associated with this Summary Plan Description. A Hospital may be a Network Transplant Facility with respect to:

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

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

New FDA Approved Drug Product or Technology does not include:

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

Non-Network Provider - A Provider who has not entered into a contractual agreement with Claims Administrator, on behalf of the Employer, or is not otherwise engaged by Claims Administrator, on behalf of the Employer, for the network associated with this Plan. Providers who have not contracted or affiliated with Claims Administrator's designated Delegate(s) for the services they perform under this Plan are also considered Non-Participating/Network Providers.

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

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

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a Benefit Period as listed in the Schedule of Benefits. Such expense does not include charges in excess of the Maximum Allowable Amount or any non-covered Services. Refer to the Schedule of Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Copayments are required unless otherwise specified in this Summary Plan Description.

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

Participant - An Eligible Person who is properly enrolled under the Plan, whose benefits are in effect and whose name appears on the Identification Card issued by the Claims Administrator, on behalf of the Employer. The Participant is the person (who is not a Dependent) on whose behalf the Plan is established.

Pharmacy and Therapeutics Committee - an external advisory committee that is responsible for developing, managing, updating, and administering the drug formulary system. P&T Committees are comprised of primary care and specialty physicians, pharmacists, and other health care professionals. Committees may also include nurses, legal experts, and administrators.

Plan – The group health benefit Plan provided by the Employer and explained in this Summary Plan Description, which also serves as the legal Plan document.

Post-Service Claim – a claim that is filed for payment of Benefits after medical care has been received.

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

Pre-Service Claim – a claim for which the Plan requires notification or approval prior to receipt of medical care for full Benefits.

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.

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

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
 1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
 2. Surgery; or
 3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A Provider that:
 1. is licensed as such, where required;
 2. is equipped mainly to do Surgery;
 3. has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present;
 4. is not an office maintained by a Physician for the general practice of medicine or dentistry; and
 5. is equipped and ready to initiate Emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills (i.e. CPR, airway management, use of the automatic external defibrillator and conventional defibrillator).

- **Birth Center** - a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
 1. constituted, licensed, and operated as set forth in the laws that apply;
 2. equipped to provide low-risk maternity care;
 3. adequately staffed with qualified personnel who:
 - a. provide care at childbirth;
 - b. are practicing within the scope of their training and experience; and
 - c. are licensed if required; and
 4. equipped and ready to initiate Emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

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

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

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.
- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
 1. provides room and board and nursing care for its patients;
 2. has a staff with one or more Physicians available at all times;
 3. provides 24 hour nursing service;
 4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
 5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

1. nursing care;
 2. rest care;
 3. convalescent care;
 4. care of the aged;
 5. Custodial Care;
 6. educational care;
 7. treatment of alcohol abuse; or
 8. treatment of drug abuse.
- **Pharmacy** - An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physician -**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
 - a. covered by the Plan;
 - b. required by law to be covered when rendered by such practitioner; and
 - c. within the scope of his or her license.

Physician does not include:

1. the Covered Person; or
2. the Covered Person's Spouse, parent, child, sister, brother, or in-law.

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

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial Provider or similar place.

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

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

Retiree – A former employee of Battelle or of a participating employer who, on the date of his/her termination on account of retirement, meets all of the Plan's eligibility requirements (or the eligibility requirements for disability under the terms of a long-term disability plan maintained by the Employer).

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

Specialty Guideline Management (SGM) - a utilization management program that helps ensure appropriate utilization of specialty medications. Please refer to the *Covered Services* section of this Summary Plan Description for a more complete explanation.

Spouse - The (a) spouse of a Participant as recognized under the laws of the state in which the Participant is domiciled, the (b) same-sex registered partner of a PNWD, or the same or opposite-sex registered partner of a BCO, BSCI, BNBI or BEUK Participant during the period that an individual is a registered partner of a Participant under applicable state or local laws. The provisions of clause (b) shall only apply to the treatment of the registered partner under the Plan and shall not affect the status of the registered partner as a Spouse under any other benefit plan, or the treatment of the registered partner under any state or federal laws, including ERISA and the Code. The status of a registered partner will terminate as provided under applicable state or local laws and such termination shall be treated under the Plan as a divorce.

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

- your discharge from an Emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an Emergency department or other care setting to another facility; or
- your transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Summary Plan Description - This summary of the terms of your health benefits.

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

Urgent Care Claim – a claim that requires notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain that cannot be adequately managed without the care or treatment requested.

Years of Credited Service – Twelve consecutive months of Active Service in a salaried employment status after June 30, 1976, at Battelle Memorial Institute (including BCO and PNWD), BSCI, BNBI, and/or any other participating employer. You lose your Years of Credited Service earned before a termination of employment unless you complete at least three consecutive Years of Credited Service in a continuous period of employment ending on your retirement date. Salaried-Less-Than-Full-Time (SLTFT) service is pro-rata reduced based on scheduled working time as a percent (i.e. 80%, 50%, etc.). Salaried staff in a full-time status will receive credit for a partial year of service only in the year of termination. Contact the benefits office if you have a question concerning your number of Years of Credited Service.

Years of Credited Service include the period during which a participant is eligible for and receives benefits from the BCO or PNWD LTD Plan.

Notwithstanding the foregoing, solely for purposes of eligibility for Retiree Insurance, staff members are considered to be in “Active Service” during the period for which they are eligible for continuation of medical and dental benefits under Battelle Operating Guide policy 140-4 “Involuntary Terminations – Severance Pay”.

ELIGIBILITY, ENROLLMENT, TERMINATION, CONTINUATION AND CONVERSION

Eligibility

Your participation in medical coverage under the Plan is voluntary. Upon enrollment in the Plan for medical coverage, and as a condition to participation in and receiving benefits from the Plan, you and your Enrolled Dependents are subject to the Plan's terms as set forth in this document, and also as provided from time to time by the Plan Administrator or its Delegates.

If you wish to enroll in the Plan for yourself, and, if applicable, your Dependents, you must complete and return the appropriate form to the benefits office no later than the end of the month in which you terminate employment to retire. Coverage begins on the Participant's retirement date, if the benefits office receives the completed enrollment form by the end of the month in which the Participant terminates employment to retire.

Eligibility Requirements

You are eligible for coverage under the Plan upon your retirement from Active Service, if **as of the date of such retirement** you meet all of the following requirements:

- You are age 55 with 10 or more Years of Credited Service after June 30, 1976. (For salaried staff members of BCO terminated due to a reduction in force, the requirements are age 50 with 20 or more Years of Credited Service.)
- You earned at least three consecutive Years of Credited Service in a continuous period of employment ending on your retirement date.
- You are covered under a Battelle-sponsored health care plan.
- You are not eligible for Medicare.
- You immediately commence pension benefits from a Battelle-sponsored qualified retirement plan.

Your coverage will continue at the same level of coverage with the same Dependents as you had under the Battelle-sponsored medical plan prior to beginning coverage under this Plan.

If you do not elect coverage under this Plan at the time of retirement from Active Service with Battelle (or an affiliate covered by the Plan), you will not be eligible to elect coverage under this Plan at a later date except as provided for Spouses employed by Battelle.

Eligibility for Disabled Participants

You are eligible to continue coverage after termination of employment for disability, regardless of age or Years of Credited Service, if you meet all of the following requirements:

- You incur a disability as an active salaried staff member.

- That same disability qualifies you for benefits from the Group Long Term Disability Insurance Plan for Salaried Staff Members of Battelle Memorial Institute (the “BCO LTD Plan”) or the Battelle Pacific Northwest Laboratories Employees’ Long-Term Disability Plan (the “PNWD LTD Plan”).
- You are covered by a Battelle-sponsored health care medical plan as of the day prior to beginning benefits under the BCO LTD Plan or PNWD LTD Plan.
- You have received at least 24 months of benefits (including retroactive payments, if applicable) from the BCO LTD Plan or PNWD LTD Plan.

Your coverage will continue at the same level of coverage with the same Dependents as you had under the Battelle-sponsored medical plan prior to beginning coverage under this Plan.

If you do not elect coverage under this Plan at the time you are first eligible due to a long term disability, you will not be eligible to elect coverage under this Plan at a later date except as provided for Spouses employed by Battelle.

Your coverage under the Plan due to your disability will end when your benefits from the BCO LTD Plan or PNWD LTD Plan terminate. If your benefits continue to (or past) your age 65, you will be eligible for benefits under this Plan only to the extent that you have met the requirements for participation as a Retiree, other than the requirement to retire from Active Service with Battelle. Your Years of Credited Service for purposes of determining your eligibility for continuing coverage as a Retiree will include the period during which you received benefits from the BCO LTD Plan or PNWD LTD Plan.

Eligibility for Certain Transfers Within Battelle’s Controlled Group

If you transfer from employment with Battelle to employment with a member of Battelle’s controlled group or a subsidiary that is at least 51%-owned by Battelle (a “Battelle Group Member”), you maintain your eligibility for this Plan until your termination of employment with the Battelle Group Member (even if subsequently less than 51%-owned by Battelle). In addition, if you return directly to employment with Battelle from the Battelle Group Member (even if Battelle’s ownership is reduced to less than 51%), you maintain your eligibility for the Plan provided that the service with Battelle and the subsidiary is continuous and uninterrupted. However, only Years of Credited Service with Battelle are counted for eligibility under this Plan. In order to maintain eligibility under this provision, you must enroll in this Plan immediately upon your termination of continuous employment with Battelle and the Battelle Group Member, and coincident with your commencement of pension benefits under a Battelle-sponsored pension plan.

Medical Child Support Order

The Plan will allow election changes during the calendar year as required by a qualified court order requiring health care coverage for the child of a Participant. The court order must be submitted to the Plan Administrator for determination. An order cannot provide for a new type, form or option of benefit not otherwise provided in the Plan. In addition, the Plan will allow a Participant to drop coverage for a Dependent during the calendar year upon receipt of a qualified

court order providing for coverage of the Dependent under a Spouse's or former Spouse's health plan and written documentation satisfactory to the Plan Administrator that the child is in fact covered under the other health plan. The order will be effective prospectively only from the date the order is determined to be qualified. A copy of the Plan's procedures governing qualified medical child support orders (QMCSO) is available from the Plan Administrator at no charge.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay benefits for Covered Services related to that Inpatient Stay as long as you receive Covered Services in accordance with the terms of the Plan.

You should notify the Claims Administrator within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network benefits are available only if you receive Covered Services from Network Providers.

Deferral of Enrollment in Plan Where Retiree's Spouse is a Battelle Staff Member

If, at the time you are first eligible to become covered under this Plan, your Spouse is an active Battelle staff member, you may defer enrollment for so long as you remain continuously covered as a Dependent of your Spouse under a Battelle-sponsored medical plan. However, you must enroll in this Plan as of the first of the month after such coverage as a Dependent ends in order to maintain your eligibility for this Plan. The enrollment form must be received by the benefits office by the 7th of the month in which your coverage as a Dependent ends unless evidence satisfactory to the Plan Administrator of a hardship making it impossible for you to timely provide such enrollment form is submitted to the benefits office before the end of the month after your coverage ended. If you do not timely elect coverage under this Plan at the time your coverage ends as a Dependent of an active staff member, you will not be eligible to enroll in Retiree coverage at a later date.

You do not have to elect coverage under this Plan. Alternatively, if at the time your Spouse terminates employment with Battelle, he or she is eligible for and elects retiree coverage under the Plan, your Spouse may cover you as a Dependent; however, you will not maintain your eligibility for enrollment as a retiree. Please review the provisions regarding Dependent coverage carefully prior to making your decision, as your coverage may end sooner than if you had your own coverage as a Retiree.

Open Enrollment Period for Medical Coverage

The open enrollment period for the retiree medical and dental plans is held annually for a specified period, generally during the last quarter of the calendar year. You will be notified regarding the timing of the open enrollment period. Your elections for medical coverage, such as plan choice or level of coverage, must be made during the open enrollment period.

Specific Plan information such as monthly contributions will be provided during the open enrollment period. Such information is typically made available on the applicable websites as

soon as it is available. Eligible Persons may enroll themselves and their eligible Dependents within the month of their termination of employment from Battelle or other participating employer for retirement.

Waiver of Participation

Any person who has waived participation in the Plan is not eligible to participate in this Plan. A person is considered to have "waived participation" in the Plan as of the earlier of receipt of a written waiver of participation acceptable to the Plan Administrator, or the refusal to provide information deemed necessary or desirable by the Plan Administrator for the administration of the Plan.

Dependent.

Dependent generally refers to the Participant's Spouse/Registered Partner (unless your Spouse/Registered Partner is also enrolled in a Battelle-sponsored medical plan) and unmarried dependent children. When a Dependent actually enrolls, that person is called an Enrolled Dependent. The Plan Administrator has discretionary authority to determine who qualifies as a Dependent.

In order for an individual to be eligible for coverage as a Dependent of a Participant, the Participant must be enrolled in the Plan, must elect a level of coverage that includes the Dependent, and the Dependent must meet the eligibility requirements of the Plan. In addition, the Dependent must have been covered by a Battelle-sponsored medical Plan as a Dependent of the Participant on the day before coverage under this Plan started. If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent. Dependent coverage may be elected only for those Dependents who are covered as your Dependents under a Battelle-sponsored medical plan at the time of your retirement from Active Service with Battelle. Dependents acquired after the date of retirement are not eligible for coverage. Please refer to the *Definitions Section* of this Summary Plan Description for additional information.

Disabled Dependents.

Your unmarried child who is 23 years of age or over and who is mentally or physically incapable of self-sustaining employment may qualify for continued Dependent coverage. In order to qualify, the Dependent must meet all requirements for a Dependent under the Plan other than age, and must be primarily dependent upon you for support. Proof of mental or physical incapacity satisfactory to the Claims Administrator and evidence that the Dependent is primarily dependent upon you for support, must be submitted to the Claims Administrator within 31 days of failure to qualify as a Dependent solely because of attainment of age 23. Your Dependent must have been covered under this Plan as your Dependent when he or she attained age 23, and the incapacity must have commenced before the Dependent reached age 23. Evidence of ongoing/continued incapacity and your primary support is required at least annually.

The Participant must reimburse the Plan for any benefits that the Plan pays for a child at a time when the child did not satisfy these conditions. A Dependent also includes a child for whom coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Plan is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

Loss of Dependent Status

A former Spouse is not eligible for coverage as a Dependent under the Plan. Eligibility for a Participant's former Spouse ends as of the last day of the month in which the divorce between the Participant and Spouse is final.

A Dependent child is no longer eligible for coverage as a Dependent as of the end of the month in which he or she:

- Becomes employed as a full-time employee (other than as a seasonal or temporary employee as determined by the Plan Administrator),
- Ceases to meet the requirements to qualify as a Dependent for federal income tax purposes,
- Joins the Armed Forces of any country,
- Becomes eligible for coverage under this Plan as an employee,
- Becomes insured for benefits under any other plan funded in part or in total by Battelle,
- Ceases to qualify as a Dependent due to mental or physical incapacity for self-sustaining employment,
- Gets married, or
- Reaches age 23.

If any of your enrolled Dependents loses eligibility as described above, it is your responsibility to notify the benefits office. No right to continue coverage after the loss of Dependent status is obtained because of payments for coverage. Continuation of coverage after loss of eligibility is permitted only as required by COBRA.

Note: Dependent status will not be affected for a Dependent who is otherwise eligible to be claimed as a Dependent for federal income tax purposes but for a court order mandating that a party other than the Participant may take the federal income tax deduction.

Termination

For Participants, coverage under this Plan automatically terminates on the earliest of the following dates:

- the last day of the period for which the Participant has timely paid any required contributions for the cost of coverage under the Plan, or
- the effective date that the Plan is discontinued or amended to terminate applicable eligibility of coverage.

- the day the Plan Administrator receives notice that you or an enrolled Dependent committed fraud, misrepresentation or false information for the purpose of effecting coverage under the Plan.

Please note that coverage under this Plan will end when you become entitled to Medicare benefits (under Part A, Part B, or both), whether or not you elect to enroll in Medicare. At that time, you will automatically be enrolled in the Medicare Complement Plan for Retirees of BMI except as provided for beneficiaries who have Medicare solely because of permanent kidney failure as described in the Coordination of Benefits (COB) section of this document.

For disabled former employees treated as Retirees, your coverage under the Plan will end when your benefits from the BCO LTD Plan or PNWD LTD Plan terminate. If your benefits continue to age 65, you will be eligible for benefits under this Plan only to the extent that you have met the requirements for participation as a Retiree, other than the requirement to retire from Active Service with Battelle. Your Years of Credited Service for purposes of determining your eligibility for continuing coverage as a Retiree will include the period during which you received benefits from the BCO LTD Plan or the PNWD LTD Plan.

For Dependents, coverage automatically terminates on the earliest of the following date:

- the date the Participant's coverage terminates,
- the last day of the month in which the Participant ceases to be in a class of employees or retirees eligible for Dependent coverage,
- the last day of the period for which the Participant has timely paid any required contribution for the cost of Dependent coverage, or
- the date applicable Dependent coverage is discontinued under the Plan.

Other Events Ending Your Coverage

When any of the following happen, the Plan will provide written notice to the Participant or to the enrolled Dependent that coverage has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Participant or Dependent knowingly gave the Plan, the Plan Administrator or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Plan is in effect, the Plan Administrator has the right to demand that you pay back all benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. After the first two years, the Plan Administrator can only demand that you pay back these benefits if the written application contained a fraudulent misstatement.

Ending Event	What Happens
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Plan Administrator's staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Death of a Participant

Upon the death of the Participant, an enrolled Dependent who is a surviving Spouse may continue coverage by timely payment of the applicable premiums until the earliest of death, remarriage, employment by Battelle or a controlled group member as a salaried staff member, discontinuance of the Plan, or amendment of the Plan to discontinue applicable coverage. An enrolled Dependent other than a surviving Spouse may continue coverage after the Participant's death by timely payment of premiums until the earliest of loss of eligibility as a Dependent (other than for lack of primary support by the Participant), death of both parents covered by the Plan, employment by Battelle or a Battelle controlled group member, death of the Dependent, discontinuance of the Plan or amendment of the Plan to discontinue applicable coverage.

Payment of Medical Expenses After Death

Any medical expense benefits that remain unpaid at the Participant's death may be paid directly to the provider of medical care being reimbursed or to any of the following, at the Claims Administrator's option: surviving Spouse, mother, father, child or children, brothers or sisters, or to the executors or administrators of the estate of the Participant. Any payment under this paragraph discharges the Plan and Battelle and its controlled group members from all further liability to the extent of the payment made.

Terminating Coverage

You may drop coverage for yourself or your Dependents. You must notify the benefits office in writing by the 7th of the month preceding the month as of which you wish to terminate coverage; i.e., you must notify us by May 7th to terminate coverage effective June 1st. Otherwise, the change will be effective as soon as administratively practicable after receipt by your benefits office of your written request for termination of coverage.

Federal Continuation of Coverage (COBRA)

Under Federal law, Battelle is required to offer Enrolled Dependents the opportunity for a temporary extension of coverage under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in the *Definitions Section* of this Summary Plan Description in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you and your Enrolled Dependents, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law.

Much of the language in this section comes from the federal law that governs continuation coverage. You should call the Benefits Office if you have questions about your right to continue coverage.

Qualifying Events.

COBRA continuation coverage is a continuation of health coverage under the Employer's health Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your Spouse and/or your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Benefits Office for Fee payment requirements.

Qualifying Events for An Enrolled Dependent Who Is the Spouse of a Participant

If you are the Spouse of a Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

Qualifying Events for an Enrolled Dependent Other Than Spouse

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Participant dies;
- The parent-Participant becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a Dependent.

Qualified Beneficiary Responsibility

The Participant or Enrolled Dependent has the responsibility to inform the Plan Administrator of a death, enrollment in Medicare, divorce, legal separation, or ceasing to qualify as a Dependent

of the Participant under the Plan. This notification must be made within 60 days from whichever date is later: the date of the qualifying event or the date that coverage terminates. Check the requirements for Dependents contained in this Plan carefully to determine when an individual ceases to qualify as a Dependent under the Plan.

If your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary.

Please send your notification to the following address:

Battelle
COBRA Coordinator
505 King Avenue, Room A-1-94
Columbus, OH 43201

Employer Responsibility

Once the Plan Administrator is notified that a qualifying event has occurred, the Plan Administrator will notify covered individuals (also known as qualified beneficiaries) by mail of their right to elect continuation coverage.

If a qualified beneficiary does elect to continue coverage and pays the applicable contribution, then Battelle is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the Plan to similarly-situated Participants and Enrolled Dependents. If coverage is changed or modified for similarly situated Participants and Enrolled Dependents, continuation coverage may be similarly changed and/or modified

How to Elect COBRA Coverage?

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Parents may elect COBRA continuation coverage on behalf of their children. You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. The Plan does not allow for an extension of this maximum period. If a qualified beneficiary does not elect continuation coverage within this period, all rights to elect continuation coverage will end. You will then have an additional 45 days to pay the cost of your COBRA coverage retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a Provider, inform that Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the Plan under COBRA, you have the right to change your coverage election during annual Open Enrollment.

Length of Coverage

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Participant, the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months from the date of the qualifying event.

Eligibility and Premiums

You must be covered under the Plan at the time of a qualifying event in order to be eligible to elect continuation coverage. The Plan Administrator reserves the right to verify eligibility and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary may have to pay all of the applicable contribution plus a 2% administration charge for continuation coverage. These contributions may be adjusted in the future if the applicable contribution amount changes. The initial contribution is due within 45 days after the date of election and must include payment for all months necessary to bring your coverage to the current month. Thereafter, contributions are due the first day of the month for that month's coverage. There is a grace period of 30 days for the regularly scheduled monthly contributions. This is the maximum grace period under the Plan, as the Plan does not provide for an extension beyond what is required by law.

When COBRA Ends

The law allows continuation coverage that has been elected and paid for to be terminated prior to the maximum continuation period for any of the following reasons:

- you or your Enrolled Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes eligible for Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- a qualified beneficiary notifies the Plan Administrator that he/she wishes to cancel continuation coverage;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Address Changes

In order to ensure that you receive information properly and efficiently, you must contact the COBRA Coordinator with any address changes as soon as possible. Failure on your part to do so

may result in delayed notification and loss of continuation coverage options.

If You Have Questions

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

HOW TO OBTAIN COVERED SERVICES

Benefits are provided when you obtain Covered Services from your Network Provider. **Services you obtain from a Non-Network Provider which are not an Authorized Service are not covered, except for Emergency Care.** Contact your Network Provider, or the Claims Administrator to be sure that Prior Authorization and/or pre-certification has been obtained.

Network Provider Services and Benefits

If your care is rendered by your Network Provider benefits will be provided for Covered Services. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by your Network Provider. All medical care must be under the direction of Physicians.

The Claims Administrator may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. Any further charges will be your responsibility. You may appeal this decision. See the *Complaint and Appeals Section* in this Summary Plan Description.

If there is no Network Provider who is qualified to perform the treatment you require, the Claims Administrator may approve a Non-Network Provider to provide the required Covered Services as an Authorized Service with no additional cost to you.

Relationship of Parties (Administrator - Network Providers)

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

The Claims Administrator shall not be responsible for any claim or demand as a result of damages arising out of, or in any manner connected with, any injuries suffered by a Covered Person while receiving care from any Provider or in any Provider's facilities.

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

Restrictions on Choice of Providers

Except for Emergency, your medical care is not covered if services are obtained from a Non-Network Provider without prior approval.

Not Liable for Provider Acts or Omissions

The Claims Administrator and/or the Plan Administrator are not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Claims Administrator and/or the Plan Administrator based on what a Provider of health care, services or supplies, does or does not do.

Identification Card

When you receive care from your Network Provider or other Provider, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under the Plan. To be entitled to such services or benefits you must be a Covered Person on whose behalf all applicable Fees under the Plan have been paid. Any person receiving services or other benefits to which he or she is not then entitled under the provisions of the Plan will be responsible for the actual cost of such services or benefits.

HEALTH CARE MANAGEMENT

Health Care Management is included in your health care benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Covered Persons by assuring the use of appropriate procedures, setting (place of service), and resources through Case Management and through Precertification review requirements which may be conducted either prospectively (Prospective Review), concurrently (Concurrent Review), or retrospectively (Retrospective Review).

If you have any questions regarding Health Care Management or to determine which services require Pre-certification, call the Pre-certification telephone number on the back of your Identification Card or refer to the Claims Administrator's web site, www.anthem.com.

Covered Persons are entitled to receive upon request and free of charge reasonable access to and copies of documents, records, and other information relevant to the Covered Person's Precertification request.

Your right to benefits for Covered Services provided under the Plan is subject to certain policies, guidelines and limitations, including, but not limited to, the Claims Administrator's medical policy and Clinical Guidelines.

A description of each Health Care Management feature, its purpose, requirements and effects on benefits is provided in this section.

Clinical Guidelines

The Claims Administrator uses clinical guidelines to assist in the interpretation of Medical Necessity. The clinical guidelines include the Claims Administrator's Corporate Medical policy, nationally recognized utilization review guidelines, Claims Administrator developed Medical Review/Utilization Review Criteria, Medicare Guidelines, and other decision support material. However, the Summary Plan Description takes precedence over the clinical guidelines. Medical technology and standards of care are constantly changing and the Claims Administrator reserves the right to review and update the clinical guidelines periodically.

Precertification

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

Precertification is a Health Care Management feature which requires that an approval be obtained from the Claims Administrator before incurring expenses for certain Covered Services. The Plan's procedures and timeframes for making decisions for Precertification requests differ

depending on when the request is received and the type of service that is the subject of the Precertification request.

Urgent Review means a review of medical care or treatment that in the opinion of the treating Provider or any Physician with knowledge of the Covered Person's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function based on a prudent layperson's judgment, or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without such care or treatment. Applying the prudent layperson standard, the Claims Administrator may determine that an Urgent Review should be conducted. Concurrent Reviews of continued Hospital stays will always be considered urgent.

When care is evaluated, both Medical Necessity and appropriate length of stay for Inpatient admissions will be determined. Medical Necessity includes a review of both the services and the setting. The care will be covered according to your benefits for the number of days approved unless the Claims Administrator's Concurrent Review determines that the number of days should be revised. If a request is denied, the Provider may request a reconsideration. The Claims Administrator's Physician reviewer will be available by telephone for the reconsideration within one business day of the request. An expedited reconsideration may be requested when the Covered Person's health requires an earlier decision.

Generally, the ordering Provider, facility or attending Physician may call to request a Precertification 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 Precertification request. The authorized representative can be anyone who is 18 years or older. For Urgent Reviews as defined above, the requesting Provider will be presumed to be acting as your authorized representative. For more information on the Plan's process for designating an authorized representative, call the **Precertification telephone number** on the back of your Identification Card.

It is your responsibility to obtain Precertification. You should verify that the Provider obtains the required Precertification or obtain the required Precertification yourself. If you do not obtain any required Precertification, you are responsible for all charges for services the Claims Administrator determines are not Medically Necessary and a **non-compliance penalty of \$300**. If you do not obtain the required Precertification, a Retrospective Review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services the Claims Administrator determines are not Medically Necessary.

You are responsible for obtaining Precertification for the following services:

- Inpatient admissions to Hospitals and other covered facilities (Skilled Nursing Facility, rehabilitation facility, Hospice) except for Emergency admissions and Maternity admissions which result in childbirth (including admissions of forty-eight (48) hours for normal delivery and ninety-six (96) hours for C-section delivery);

- UPPP (Uvulopalatopharyngoplasty) surgery;
- Plastic/Reconstructive surgeries for:
 1. Blepharoplasty;
 2. Rhinoplasty;
 3. Hairplasty;
 4. Panniculectomy and Lipectomy/Diastasis Recti Repair;
 5. Insertion/Injection of Prosthetic Material Collagen Implants; or
 6. Chin Implant/Mentoplasty/Osteoplasty Mandible;
- DME/Prosthetics for:
 1. Wheelchairs, special size, motorized or powered, and accessories;
 2. Hospital Beds, Rocking Beds, and Air Beds;
 3. Electronic or externally powered prosthetics; or
 4. Custom made and /or Custom fitted prefabricated orthotics and braces;
- PET (Positron Emission Tomography);
 - Private Duty Nurse services in the home setting; or
- Outpatient services for Stem Cell/Bone Marrow transplant (with or without myeloablative therapy) and, Donor Leukocyte Infusion.

For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Claims Administrator or verify that your Physician has notified the Claims Administrator of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Claims Administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Claims Administrator you may avoid financial responsibility for any Inpatient care which is determined to be not Medically Necessary under your health benefit Plan. If your Provider does not have a participation agreement with the Claims Administrator, or is a Blue Card Provider, you will be financially responsible for any care the Claims Administrator determines is not Medically Necessary.

For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Precertification Procedures

Prospective Review means a review of a request for Precertification that is conducted prior to a Covered Person's Hospital admission or course of treatment. For Prospective Reviews, a decision will be made and telephone notice of the decision will be provided to the requesting Provider, as soon as possible, taking into account the medical circumstances, but not later than two business days from the time the request is received by the Claims Administrator.

For Urgent reviews, telephone notice will be provided to the requesting Provider as soon as possible taking into account the medical urgency of the situation, but not later than two calendar days from the time the request is received by the Claims Administrator.

If additional information is needed to certify benefits for services, the Claims Administrator will notify the requesting Provider by telephone and send written notification to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review as soon as possible, but not later than two business days after receipt of the request. For Urgent Reviews the Claims Administrator will notify the requesting Provider by of the specific information necessary to complete the review within 24 hours after receipt of the request by the Claims Administrator. Written notice will be sent following the request by telephone.

The requested information must be provided to the Claims Administrator within 45 calendar days from receipt of our request. **Note:** If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. For Urgent Reviews, the requested information must be provided within 48 hours after the Claims Administrator's request for specific information.

A decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, but not later than two business days (two calendar days for Urgent Reviews) after the Claims Administrator's receipt of the requested information.

If a response to the Claims Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Claims Administrator's possession and telephone notice of the decision will be provided to the requesting Provider not later than two business days (two calendar days for Urgent Reviews) after the expiration of the period to submit the requested information.

Written notice of Prospective Review decisions will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

Concurrent Review

Concurrent Review means a review of a request for Precertification that is conducted during a Covered Person's Inpatient Hospital stay or course of treatment. As a result of Concurrent Review, additional benefits may be approved for care which exceeds the benefit(s) originally authorized by the Claims Administrator's Health Care Management staff.

If a request for Concurrent Review is received within 24 hours prior to the expiration of the end of the approved care, and it qualifies for Urgent Review, a decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by the Claims Administrator. If the request is not received within 24 hours prior to the end of the approved care, the decision will be made and telephone notice of the decision will be provided to the requesting Provider within two calendar days from the time the request is received by the Claims Administrator. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

For Concurrent Reviews that do not qualify for Urgent Review, the decision will be made and telephone notice will be provided to the requesting Provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) within two business days from the time the request is received by the Claims Administrator.

If additional information is needed to certify benefits for services for a Concurrent Review that does not qualify for Urgent review, the Claims Administrator will notify the requesting Provider by telephone and will send written notice to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review within two business days after receipt of the request.

You or your authorized representative and the requesting Provider have 45 calendar days from receipt of the Claims Administrator's request to provide the information to the Claims Administrator. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. A decision will be made and telephone notice of the decision will be provided to the requesting Provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) within two business days from the time the requested information is received by the Claims Administrator. If a response to the Claims Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Claims Administrator's possession and telephone notice of the decision will be provided to the requesting Provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) not later than two business days after expiration of the period to submit the requested information.

The Claims Administrator will not reduce or terminate a **previously approved** on-going course of treatment until you or your authorized representative receive telephone notice of the Claims Administrator's decision and have an opportunity to appeal the decision and receive notice of the appeal decision.

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after health care services have been provided to a Covered Person. If Precertification is required but not obtained prior to the service being rendered, the Claims Administrator will conduct a Retrospective

Review. Further, if a service is subject to a clinical guideline, but precertification is not required for that service, the Claims Administrator may conduct a Retrospective Review.

Retrospective review may be completed before a claim is submitted (pre-claim) or after a claim is submitted (post-claim). It does not include a post-claim review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

For Pre-claim Retrospective review, a decision will be made and notice will be provided to you or your authorized representative and the Provider(s) within 2 business days from the time the request is received by the Claims Administrator. If additional information is needed to certify benefits for services, the Claims Administrator will notify you or your authorized representative and the requesting Provider in writing of the specific information necessary to complete the review within 2 business days after receipt of the request.

You or your authorized representative and the requesting Provider have 45 calendar days from receipt of the Claims Administrator's request to provide the information to the Claims Administrator. **Note:** If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day.

A decision will be made and notice will be provided to you or your authorized representative and the Provider(s) within 2 business days from the time the requested information is received by the Claims Administrator. If a response to the Claims Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Claims Administrator's possession and notice will be provided to you and your authorized representative and the Provider(s) not later than 2 business days after expiration of the period to submit the requested information.

For Post-claim Retrospective review, a decision will be made within 30 calendar days from the time the claim is received by the Claims Administrator. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 30 calendar days from the time the claim is received by the Claims Administrator.

If additional information is needed to certify benefits for services, the Claims Administrator will notify you or your authorized representative and the requesting Provider in writing of the specific information necessary to complete the review within 30 calendar days after receipt of the claim.

You or your authorized representative and the requesting Provider have a reasonable amount of time taking into account the circumstances, but not less than forty-five calendar days from the date of the Claims Administrator's request to provide the additional information to the Claims Administrator. A decision will be made within 15 calendar days from the time the requested information is received by the Claims Administrator. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 15 calendar days of receiving the requested information.

Case Management (includes Discharge Planning)

Case Management is a Health Care Management feature designed to assure that your care is provided in the most appropriate and cost effective care setting. This feature allows the Claims Administrator to customize your benefits by approving otherwise non-covered Services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Claims Administrator's Health Care Management staff. In managing your care, the Claims Administrator has the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. Care must be received from a Network Provider to be a Covered Service, except for Emergency Care. **If you use a Non-Network Provider, your entire claim will be denied unless the services are approved by the Claims Administrator.**

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

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Summary Plan Description. Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Plan payment for Covered Services will be limited by any applicable Copayment, Benefit Period maximum, or Lifetime Maximum in this Summary Plan Description.

Preventive Care Services

Preventive Care benefits may vary based on the age, sex, and personal history of the individual, and as determined appropriate by the Claims Administrator's clinical coverage guidelines. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. **Covered Persons who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.**

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. **(Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not**

Covered Services.) Examinations include, but are not limited to:

1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines,
2. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests,
3. Adult routine physical examinations,
4. Pelvic examinations,
5. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis,
6. Annual dilated eye examination for diabetic retinopathy, and
7. Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follow the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians. These include, but are not limited to:
 - Hepatitis A vaccine
 - Hepatitis B vaccine
 - Hemophilus influenza b vaccine (Hib)
 - Influenza virus vaccine
 - Rabies vaccine
 - Diphtheria, Tetanus, Pertussis vaccine
 - Mumps virus vaccine
 - Measles virus vaccine
 - Rubella virus vaccine
 - Poliovirus vaccine.

• **Screening examinations, include:**

1. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts;
2. Routine hearing screening;
3. Routine screening mammograms; Additional mammography views required for proper evaluation and any ultrasound services for screening of breast cancer, if determined Medically Necessary by your Physician, are also covered;
4. Routine cytologic and chlamydia screening (including pap test);
5. Routine bone density testing for women;
6. Routine prostate specific antigen testing; and
7. Routine colorectal cancer examination and related laboratory tests. Examinations and

tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Diabetes self management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Physician Office Services

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

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

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

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

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

Inpatient Services

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

- charges from a Hospital or other Provider for room, board and general nursing service

- ancillary services; and
- professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services, include:

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

Ancillary Services, include:

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

Professional Services, include:

- **Medical care visits** limited to one visit per day by any one Physician;
- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time;
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians;
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded;
- **Surgery and the administration of general anesthesia; and**

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

Copayment Waiver. When a Covered Person is transferred from one Hospital or facility to another Hospital or other facility on the same day, any Copayment stated in dollars per admission in the Schedule of Benefits is waived for the second admission. Copayments stated as a percentage are not waived.

Outpatient Services

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

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care Services** section.

Emergency Care and Urgent Care

Emergency Care (including Emergency Room Services)

Medically Necessary Services which the Claims Administrator determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered and reimbursed by the Plan at the Network level. The Covered Person is not required to pay more than would have been required for services from a Network Provider. In addition, if you contact your Physician and are referred to a Hospital Emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Whenever you are admitted as an Inpatient directly from a Hospital Emergency room, the Emergency Room Services Copayment for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is required. You must notify the Claims Administrator or verify that your Physician has notified the Claims Administrator of your admission within 24 hours or as soon as possible within a reasonable period of time. When the Claims Administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Claims Administrator you may avoid financial responsibility for any Inpatient care which is determined to be not Medically Necessary under your health benefit Plan. If your Provider does not have a participation agreement with the Claims Administrator, on behalf of the Employer, or is a Blue Card provider, you will be financially responsible for any care the Claims Administrator determines is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will not be covered unless the continuation of care is authorized and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment. If you experience an accidental injury or a medical problem, the Claims Administrator will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an Emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an Emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your Schedule of Benefits for benefit limitations.

Ambulance Services

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

- from your home, scene of accident or medical Emergency to a Hospital;
- between Hospitals;
- between Hospital and Skilled Nursing Facility; or
- from a Hospital or Skilled Nursing Facility to your home.

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

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

- When a Covered Person is required by the Claims Administrator to move from a Non-Network Provider to a Network Provider.

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

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

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

Diagnostic Services

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

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

- Positron emission tomography (PET scanning).

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

Surgical Services

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

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by the Employer.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact the Claims Administrator for more information.

Covered Surgical Services include, but are not limited to:

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

Sterilization

Regardless of Medical Necessity, sterilization is covered.

Mastectomy Notice

A Covered Person who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act (WHCRA) became effective for this Plan, and who elects breast reconstruction, will

also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same Copayment provisions otherwise applicable under the Plan. For more information regarding your WHCRA rights under an employer-sponsored group health plan, call the Department of Labor's Employee Benefits Security Administration (EBSA) toll free at 1.866.444.EBSA(3272) or visit the EBSA website at www.dol.gov/ebsa/.

Therapy Services

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

Physical Medicine Therapy Services

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

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).
- **Spinal manipulation services** to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulation whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Spinal Manipulations as specified in the Schedule of Benefits.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Physical Medicine and Rehabilitation Services

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

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

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

Home Care Services

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

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.),
- Diagnostic Services,
- Medical/Social Services,
- Nutritional Guidance,

- Home Health Aide Services,
- Therapy Services (Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.),
- Medical/Surgical Supplies,
- Durable Medical Equipment,
- Prescription Drugs (only if provided and billed by a Home Health Care Agency), and
- Private Duty Nursing.

Home infusion therapy will be paid only if you obtain prior approval from the Claims Administrator's Home Infusion Therapy Delegate (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

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

Covered Services include the following only when authorized by your Physician:

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

Human Organ and Tissue Transplant Services

For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.

Covered Transplant Procedure

A Covered Transplant Procedure is any Medically Necessary human organ and tissue transplant as determined by the Claims Administrator including necessary acquisition costs and preparatory myeloblastic therapy.

Covered Transplant Services

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

Notification

The Plan strongly encourages the Covered Person to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Covered Person in maximizing their benefits by providing coverage information including details regarding what is covered and whether any Medical Policies, network requirements or Summary Plan Description exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Covered Person.

Covered Transplant Benefit Period

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

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may

be allowed for two companions. The Covered Person 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.

Medical Supplies, Durable Medical Equipment, and Appliances

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

Covered Services include, but are not limited to:

- **Medical and surgical supplies** - Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly. Prescription drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depo-Provera.
- **Durable medical equipment** - The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. **Non-covered** items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports, and corsets or other articles of clothing.
- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
 1. Replace all or part of a missing body part and its adjoining tissues; or
 2. Replace all or part of the function of a permanently useless or malfunctioning body part.

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

1. Aids and supports for defective parts of the body including but not limited to internal

heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;

2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant)
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act;
4. Minor devices for repair such as screws, nails, sutures and wire mesh;
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session);
7. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract - formulae and supplies are also covered)
8. Cochlear implant;
9. Electronic speech aids in post-laryngectomy or permanently inoperative situations;
10. "Space Shoes" when used as a substitute device when all or a substantial portion of the forefoot is absent; and
11. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

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

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

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

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

1. Cervical collars;
2. Ankle foot orthosis;
3. Corsets (back and special surgical);
4. Splints (extremity);

5. Trusses and supports;
6. Slings;
7. Wristlets;
8. Built-up shoe; and
9. Custom made shoe inserts.

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

Non-Covered Services include but are not limited to:

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

Accident Related Dental Services

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means services or treatment performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

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

- oral examinations;
- x-rays;
- tests and laboratory examinations;
- restorations;
- prosthetic services;

- oral surgery;
- mandibular/maxillary reconstruction; and
- anesthesia.

Maternity Services

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn. Maternity services for a Dependent daughter are also covered.

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

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 caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. The antepartum, intrapartum, and postpartum course of the mother and infant;
 2. The gestational stage, birth weight, and clinical condition of the infant;
 3. The demonstrated ability of the mother to care for the infant after discharge; and
 4. The availability of post discharge follow-up to verify the condition of the infant after discharge.
- Covered Services include at-home post delivery care visits at your residence by a Physician

or Nurse when performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage includes, but is not limited to:

1. Parent education;
2. Physical assessments;
3. Assessment of the home support system;
4. Assistance and training in breast or bottle feeding; and
5. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office.

Elective Abortion - Regardless of Medical Necessity, the Plan pays Covered Services from a Provider for elective abortion accomplished by any means.

Mental Health/Substance Abuse Services

Covered Services include but are not limited to:

- **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family Covered Persons to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. Room and board charges are Covered Services only when an Inpatient stay is authorized by the Claims Administrator or the Claims Administrator's Delegate.
- **Partial hospitalization** - a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care. The program usually is offered in an acute setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment of at least 4 to 6 hours of treatment per day. Patients are expected to participate up to 5 days per week.
- **Intensive Outpatient treatment or day treatment** - a structured program, offered at least 3 times per week for at least 3 hours per day. The program may be managed by a licensed Mental Health professional with a psychiatrist on staff. Therapy is provided by a licensed Mental Health professional.
- **Outpatient treatment, or individual or group treatment** - office-based services, for example diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed Mental Health professional and is coordinated with the psychiatrist.

Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

Non-Covered Mental Health/Substance Abuse Services, include:

- Residential Treatment services. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities,
- Custodial or Domiciliary Care,
- Supervised living or half-way houses, and
- Room and board charges unless the treatment provided meets the Claims Administrator's Medical Necessity criteria for Inpatient admission for your condition.

Services for Mental Health/Substance Abuse Services will be paid only if you obtain prior approval from the Plan's Mental Health/Substance Abuse Delegate and receive services from the Provider designated by that approval.

Copayments are specified in the Schedule of Benefits.

Prescription Drugs

Administered by CVS Caremark

Prescription drug benefits under the Plan are available through the Plan's current pharmacy benefit manager, CVS Caremark. Benefits are not available for all drugs; generally, the Plan provides Benefits for drugs that are on the Formulary used by CVS Caremark. However, there are limits and exceptions to coverage for certain drugs that are on the Formulary. The Plan provides Benefits for some drugs on the Formulary only where the diagnosis is consistent with Prior Authorization criteria.

In addition, the Plan does not pay any Benefits for some drugs that are on the Formulary such as those for sexual dysfunction, weight loss, or cosmetic purposes. However, there may be a discount available on certain non-Formulary drugs.

The level of Benefits provided for specific drugs is dependent upon whether the drug is a Generic, Formulary or non-Formulary drug. To identify the category that your drug(s) falls into, you can view the Formulary on the CVS Caremark website (www.caremark.com).

You may purchase covered medications through either the retail program for short-term medications (up to a 34-day supply) or the Mail Order Program for maintenance medications (up to a 90-day supply) or specialty medications (up to a 30-day supply). Please note that maintenance medications must be ordered through the Mail Order Pharmacy. However, when first starting the medication you are permitted to use retail for the initial 34 day prescription and two refills.

Participants may also choose to fill maintenance medications at a CVS Retail Pharmacy and receive an 84 to 90 day supply for their mail order co-pay instead of ordering through the Mail Order Pharmacy. Please note that not all covered medications are eligible for this program, but they may still be filled at CVS (or any other network retail Pharmacy) for a one month supply only, and with the standard retail co-pay. Participants may still elect to use the Mail Order Pharmacy for any covered medication and pay the mail order co-pay if they choose.

CVS Caremark Retail Pharmacy Program

To fill prescriptions at a retail Pharmacy, you must present your CVS Caremark card at a network Pharmacy and pay the applicable Copay at the time of purchase. The Plan does not provide Benefits for prescription purchases from Pharmacies that are not in the CVS Caremark network and will not accept paper claim forms for retail prescription drug purchases.

Generic Drugs\$10 Copay
Formulary Brand Name Drugs.....\$36 Copay*
Non-Formulary Brand Name Drugs.....\$55 Copay*

CVS Caremark Mail Order Pharmacy Program

For mail order, you submit prescriptions to the CVS Caremark Mail Order Pharmacy by mail. You may also submit on-line or over the phone for refills. Certain drugs are not covered by mail order.

Generic Drugs\$20 Copay
Formulary Brand Name Drugs..... \$72 Copay*
Non-Formulary Brand Name Drugs..... \$110 Copay*
Specialty Drugs\$80 Copay

*If you elect a Brand Name Drug when a generic is available, you will be responsible for both your Copay and the price difference between the Brand Name and the Generic Drug.

How To Use The CVS Caremark Mail Order Pharmacy Program

Ask your physician to prescribe needed medications for up to the maximum dispensing limit stated earlier in this benefit, plus refills. If you're presently taking medication, ask your physician for a new prescription. Make sure that you have at least a 14- to 21-day supply on hand for each drug at the time you submit a refill prescription to CVS Caremark. To obtain additional details about the Mail Order Pharmacy Program, contact the Benefits Office or CVS Caremark at the number listed on the back of your prescription drug card.

Specialty Pharmacy Services

The CVS Caremark Specialty Pharmacy is designed for individuals with chronic or genetic conditions. This benefit offers convenient delivery of your specialty medicines, personalized service, and educational support for your specific therapy. CVS Caremark assigns a team of professionals to help you successfully manage your condition and improve your quality of life. This service includes 24-hour phone access to a clinical pharmacist for consultation at no

additional cost to you. If your medication qualifies for Specialty Pharmacy Services, CVS Caremark will notify you at the time you fill your specialty prescription with CVS Caremark.

Prior Authorization and Post Limit Prior Authorization

Prior Authorization may be required for certain Prescription Drugs, or the prescribed quantity of a particular drug if there is a quantity limit in place. Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the Pharmacy's computer system and the pharmacist is instructed to have the member contact the Claims Administrator. The Plan uses pre-approved criteria, developed by the Claims Administrator's Pharmacy and Therapeutics Committee and reviewed and adopted by the Employer. The Claims Administrator communicates the results of the decision to the patient. The Claims Administrator may contact your prescribing Physician if additional information is required to determine whether Prior Authorization should be granted.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the Complaint and Appeals section of this Summary Plan Description.

Specialty Guideline Management

Specialty Guideline Management (SGM) is a utilization management program that helps ensure appropriate utilization of specialty medications. SGM is more robust than traditional Prior Authorization as it includes:

- Both concurrent and prospective clinical review components according to evidence-based medicine; ongoing monitoring process ensures that the specialty medication continues to be appropriate, safe and effective for the patient throughout the duration of therapy
- Pharmacogenomics testing and other lab data are required for certain drugs to help ensure therapy effectiveness
- SGM criteria are developed by clinicians on the Specialty Pharmacy Clinical Development team. The criteria are established according to evidence-based guidelines, including standard compendia, national guidelines, current literature and clinical trial data.
- If you are prescribed a Specialty Medication, you can call Caremark Connect toll-free at 1-800-237-2767 or visit www.caremark.com to get started. They will review your needs, contact you physician and determine coverage. You will be notified of the determination shortly. If your request is denied, you have the right to appeal through the appeals process outlined in the Complaint and Appeals section of this Summary Plan Description.

“Specialty” refers to medications that include several (but not necessarily all) of the following characteristics:

- Require a customized medication management program, including medication use review, patient training, coordination of care and adherence management for successful use
- More frequent monitoring and training
- FDA-mandated REMS program as condition of approval

- Unique handling, distribution, and/or administration requirements
- High cost
- Route of administration could be oral, inhaled, infused or injected
- Target chronic or complex disease states
- Produced through biological processes

For a current list of the drugs requiring Prior Authorization, Post Limit Prior Authorization after a Quantity Limit, or Specialty Guideline Management, please contact the Battelle Benefits Office or CVS Caremark at the number on the back of your ID card.

Drugs Covered

- Legend and non-legend drugs. Exceptions: See Exclusions list below.
 - A.D.D./Narcolepsy medications for individuals through the age of 18 years old.
 - Diabetic Care: Alcohol swabs, disposable blood/urine glucose/acetone testing agents, disposable insulin needles/syringes, insulin, lancets and lancet devices covered in full effective May 1, 2009.
 - Oral Contraceptives: 91 day Regimen at Retail/Mail: Seasonalle, Seasonique, Jolessa, Quasense
 - Oral Contraceptives: 21 & 28 day Regimen at Retail/Mail: Apri, Brevicon, Cyclessa, Ortho-Novum, Levlin, Mircette, Necon, Norinyl & others
 - Compounded medication's of which at least one ingredient is a legend drug.
 - State Law Rx Required: Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.
 - Depo-Provera: 90 day maximum
 - Smoking Deterrents

Exclusions (Drugs Not Covered)

- Anti-Obesity
- Botox Cosmetic (botulinum toxin A)
- CNS Stimulants (USC 18200)
- Erectile Dysfunction Agents: (Cialis, Levitra, Viagra)
- Intrauterine Devices, Diaphragms, Transdermal Rings
- Therapeutic Devices or Appliances unless listed as a covered product.

Prior Authorization Drugs: For these categories of drugs, Prior Authorization is required:

- Narcolepsy: Provigil, Nuvigil
- Acne Agents, Topical: Tazorac {Ages 26 & Older}
- Anti Fungal Agents, Oral: Diflucan, Lamisil, Sporanox

Quantity Limit Drugs with Post Limit Prior Authorization: For these categories of drugs, Prior Authorization is required after the quantity limit has been met:

- Anti-Emetics: Aloxi, Anzemet, Cesamet, Emend, Kytril, Marinol, Zofran
- Anti-Migraine Agents: Amerge, Axert, Frova, Imitrex Tablets, Imitrex Injection, Imitrex Nasal Spray, Maxalt, Maxalt MLT, Relpax, Treximate, Zomig, Zomig ZMT, Zomig Nasal Spray, Migranal Nasal Spray

- Sedative/Hypnotics: Ambien, Ambien CR, Dalmane, Doral, Halcion, Lunesta, ProSom, Restoril, Rozerem, Sonata

Specialty Guideline Management Drugs: For these categories of drugs, Specialty Guideline Management is required:

- Asthma: Xolair
- Crohn's Disease: Cimzia, Humira, Remicade, Tysabri
- Cystic Fibrosis: Pulmozyme, TOBI
- Growth Hormone & Related Disorders: Genotropin², Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Tev-Tropin, Zorbtive, Increlex
- Hematopoietics: Aranesp, Epogen, Leukine, Mozobil, Neulasta, Neumega, Neupogen, Procrit
- Hemophilia, Von Willebrand Disease & Related Bleeding Disorders: Advate, Alphanate, Alphanine SD, Bebulin VH, BeneFIX, Feiba VH, Helixate FS, Hemofil M, Humate-P, Koate-DVI, Kogenate FS, Monarc M, Monoclata-P, Mononine, NovoSeven², Profilnine SD, Proplex T, Recombinate, Refacto, RiaSTAP, Stimate, Xyntha
- Hepatitis C: Infergen, Pegasys², PEG-Intron², Rebetol Solution, rebavirin caps (REBETOL)¹, ribavirin tabs (COPEGUS)¹
- Hereditary Angioedema: Cinryze
- HIV Medications: Fuzeon, Serostim
- Hormonal Therapies: Eligard, Firmagon, H.P. Acthar Gel, leuprolide acetate (LUPRON)¹, Lupron Depot², Supprelin LA, Trelstar, Vantas, Zoladex
- Immune Deficiencies & Related Disorders: Carimune², Cytogam, Flebogamma², GamaSTAN S/D, Gammagard², Gamunex, Immune Globulin, Octagam, Polygam S/D, Privigen, Rhophylac, Vivaglobin, WinRho SDF
- Lysosomal Storage Disorders: Aldurazyme, Ceredase, Cerezyme, Elaprase, Fabrazyme, Myozyme, Naglazyme
- Macular Degeneration: Lucentis, Macugen, Visudyne
- Multiple Sclerosis: Avonex, Betaseron, Copaxone, Extavia, Rebif, Tysabri)
- Oncology: Afinitor, Gleevec, Hycamtin, Nexavar, Revlimid, Sprycel, Sutent, Tarceva, Tassigna, Temodar, Thalomid, Tykerb, Xeloda, Zolinda
- Osteoarthritis: Euflexxa, Hyalgan, Orthovisc, Supartz, Synvisc, Synvisc One
- Osteoporosis: Forteo
- Psoriasis: Amevive, Enbrel, Humira, Remicade, Stelara
- Pulmonary Arterial Hypertension: Adcirca, epoprostenol sodium¹, Letairis, Remodulin, Revaitio, Tracleer, Tyvaso, Ventavis
- Pulmonary Disease: Aralast²
- Renal Disease: Sensipar
- Respiratory Syncytial Virus: Synagis
- Rheumatoid Arthritis: Cimzia, Enbrel, Humira, Kineret, Orencia, Remicaid, Simponi

Drugs covered at 100% Copay (discount only) at Retail **Excluded at Mail-Order**

- U37120 ANTI-WRINKLE AGENTS
- U27110 RUBELLA VACCINES
- U27120 RUBEOLA VACCINES
- U27130 POLIO VACCINES

- U27140 MUMPS VACCINES
- U27150 DT, DPT VACCINES & TETANOUS
- U27160 TETANUS TOXOID & ANTITOXINS
- U27170 DIPHTHERIA TOXOID &
- U27180 VACCINES: MISCELLANEOUS
- U27190 CHICKEN POX VACCINES
- U27210 INFLUENZA VACCINE
- U27220 RESPIRATORY VACCINES
- U27300 ANTIVENINS
- U37840 HAIR REMOVERS
- U37900 HAIR GROWTH STIMULANTS
- U39400 GLUCOSE ELEVATING AGENTS
- U48110 HEMATINICS: IRON
- U48120 HEMATINICS: IRON COMBINATIONS
- U48200 HEMATINICS: LIVER/B-COMPLEX
- U48300 HEMATINICS: VITAMIN
- U48400 HEMATINICS: OTHER
- U52160 INFERTILITY MEDICATIONS
- U52400 ANABOLIC STEROIDS
- U53520 NORMAL SERUM ALBUMIN
- U60200 FLUORIDE SUPPLEMENTS
- U60500 CALCIUM SUPPLEMENTS
- U60700 MINERAL & NUTRIENTS
- U76110 PRENATAL MULTIVITAMINS
- U76121 PEDIATRIC MULTIVITAMINS
- U76122 PEDIATRIC MULTIVITAMINS
- U76123 PEDIATRIC MULTIVITAMINS
- U76130 MULTIVITAMINS: GENERAL
- U76211 B-COMPLEX: INJECTABLE
- U76212 B-COMPLEX: ORAL
- U76221 B-COMPLEX W/ VITAMINS
- U76222 B-COMPLEX W/ VITAMINS
- U76230 B-COMPLEX: COMBINATIONS
- U76310 ASCORBIC ACID (VITAMIN C)
- U76320 VITAMIN A
- U76330 VITAMINS A & D
- U76340 VITAMIN D
- U76350 NIACIN (NICOTINIC ACID)
- U76360 THIAMINE (VIT. B 1)
- U76370 PYRIDOXINE (VIT. B6)
- U76380 VITAMIN E
- U76390 VITAMINS: MISCELLANEOUS
- U84100 IMPOTENCE MEDICATIONS
- U86000 NEEDLES AND SYRINGES

This list is a summary reference and does not contain all coverage and exclusions of the plan benefit. Drugs may be added or removed from this listing

Vision Services

This section describes the Covered Services available under your vision care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the Benefit Booklet. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

The following are Covered Services:

- * Vision examinations
- * Lenses
- * Frames

Non-Elective Contact Lenses

This benefit is available for a limited number of diagnoses and is in lieu of the standard contact lens or glasses benefit.

Please note that if you choose to utilize an offer, coupon or in-store advertisement for an in-network provider, you will have to submit your claim yourself and it will be paid as a non-network claim.

EXCLUSIONS

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

The Plan does not provide benefits for procedures, equipment, services or supplies:

- For care not received from your Network Provider, except for Emergency Care or as an Authorized Service.
- Which are determined not Medically Necessary or do not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
- Received from an individual or entity that is not a Provider, as defined in this Summary Plan Description/Plan Document.
- Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Claims Administrator.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' 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.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
- For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- For Prescription Drug Copayments you are responsible for under other coverage with other carriers or health plans.

- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
- For court ordered testing or care unless Medically Necessary.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- 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.
- Prescribed, ordered, or referred by, or received from a Covered Person of your immediate family, including your Spouse, child, brother, sister, parent, or self.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For mileage costs or other travel expenses, except as authorized by the Claims Administrator.
- Charges in excess of the Maximum Allowable Amount.
- Incurred prior to your Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere in this Summary Plan Description.
- For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law.
- 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.
- For Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional.

- For foot care only to improve comfort or appearance including, but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails except when Medically Necessary including but not limited to, foot care for diagnosis of diabetes or for impaired circulation to the lower extremities.
- For any treatment of teeth, gums or tooth related service except as otherwise specified as covered in this Summary Plan Description.
- For bariatric surgery, regardless of the purpose it is proposed or performed. 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.
- Related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
- For sex transformation surgery and related services, or the reversal thereof.
- For marital counseling.
- For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
- For hearing aids or examinations for prescribing or fitting them.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For reversal of sterilization.
- 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.
- For personal hygiene and convenience items.
- For care received in an Emergency room which is not Emergency Care, except as specified in this Summary Plan Description.
- For expenses incurred at a health spa or similar facility.

- For self-help training and other forms of non-medical self care, except as otherwise provided herein.
- For examinations relating to research screenings.
- For stand-by charges of a Physician.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy.
- Related to any mechanical equipment, device, or organ.
- For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility.
- For Private Duty Nursing Services except when provided through the Home Care Services benefit.
- Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. 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.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergiel synchronization technique (BEST) and iridology-study of the iris.
- For drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

- Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
- Treatment of telangiectatic dermal veins (spider veins) by any method.
- Drugs in quantities which exceed the limits established by the Plan.
- Orthoptics or vision training and any supplemental testing; plano (non-prescription) lenses; or two pair of eyeglasses in lieu of bifocals or trifocals.
- An eye exam or corrective eye wear required by an employer as a condition of employment.
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related.
- Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses; although no-line bifocals and blended lenses are not covered, a member may elect to apply the maximum allowance for standard lenses toward the cost of progressive lenses.
- Sub-normal vision aids.
- Experimental or non-conventional treatments or devices.
- Safety eyewear.
- Spectacle lens styles, materials, treatments or "add-ons" not shown in the Schedule of Benefits.

CLAIMS PAYMENT

How to Obtain Benefits

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

How Benefits Are Paid

This Plan shares the cost of your medical expenses with you up to the Maximum Allowable Amount. Network Providers will seek compensation from the Plan for Covered Services. When using a Network Provider you are only responsible for Copayments and non-covered charges. Network Providers have agreed to accept the Maximum Allowable Amount as payment in full. Copayments are your share of the cost for particular health services, and are generally due at the time you receive the medical service. For Covered Services subject to a Copayment, you pay a portion of the bill and the Plan pays its share of the balance. Refer to the Schedule of Benefits to see what Copayment is required for each Covered Service.

If you receive Covered Services in a Network Provider facility from a Non-Network Provider such as an anesthesiologist who is employed by or contracted with that Network Facility, benefits will be paid at 100% of billed charges. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The amount you pay may differ by the type of service you receive or by Provider.

Refer to the Schedule of Benefits to see what amount you are required to pay for each service. Claims for Covered Services do not need to be sent to the Plan in the same order that expenses were incurred.

The Plan will deny that portion of any charge which exceeds the Maximum Allowable Amount.

Payment of Benefits

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

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

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 Allowable Amount. **If services are performed by Non-Network Providers**, then you are responsible for any amounts charged in excess of the Plan's Maximum Allowable Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact the Claims Administrator for more information.

Assignment

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

Notice of Claim

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

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

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

Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to the Claims Administrator or your benefits office, or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to the Claims Administrator without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

Denial Notices

If your request is denied by the Claims Administrator, you shall timely receive a denial notice. The denial notice will provide:

- The specific reasons(s) for the denial, and, if applicable, either the specific internal rule, guideline, protocol or other similar criterion (if any) relied upon in making the denial, or a statement that a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- References to the part of the Plan on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- Appropriate information as to the steps to be taken if you desire to appeal the denial, including notice of applicable time limits, and a statement regarding your right to bring suit under Section 502(a) of ERISA following an adverse benefit determination on review;
- If the denial is based on a Medical Necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for such denial that applies the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- A description of the expedited review process for Urgent Care Claims, if applicable.

Covered Person's Cooperation

Each Covered Person shall complete and submit to the Claims Administrator such authorizations, consents, releases, assignments and other documents as may be requested by the Claims Administrator, in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. Any Covered Person who fails to cooperate (including a Covered Person who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) 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) and
- General information about your Appeals rights and information regarding the right to bring an action after the Appeals process.

BlueCard

Under the BlueCard Program, when you obtain health care services outside the geographic area the Claims Administrator serves, the amount you pay, if not covered by a flat dollar Copayment, for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto the Claims Administrator.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average

savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

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

You will be entitled to benefits for health care services received by you either inside or outside the geographic area the Claims Administrator serves if the Plan covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area the Claims Administrator serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area the Claims Administrator serves. But in no event will you be entitled to benefits for health care services, wherever you received them, that are specifically excluded or limited from coverage by the 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 Customer Service number on your ID card or go to www.anthem.com for more information about such arrangements.

GENERAL PROVISIONS

Amendments to the Plan

Battelle reserves the right at any time to change or terminate the coverage provided under this Plan and to change any amount charged for participating in this Plan at any time and without prior notice. Any such change or termination adopted by Battelle shall be on its own behalf and on behalf of each participating employer. The benefits to be provided under the Plan and the eligibility of staff members to participate in the Plan are to be determined from time to time by the Plan Administrator under the then-effective provisions of the Plan document. The Plan may be amended at any time to change or eliminate any or all benefits under the Plan. The decision to amend or terminate the Plan belongs entirely to Battelle in its sole discretion. **Benefits under this Plan do not accrue or vest to Participants or their Dependents regardless of the number of years of service with Battelle.**

Battelle has authority to amend or terminate the Plan at any time by its President or designated officer adopting a written instrument of amendment or termination. In the event of Plan termination, any remaining assets of the trust funding the Plan will be used to provide benefits due and payable under the terms of the Plan prior to being used for other permissible purposes under law. In no event will the assets be used for the benefit of the employer. Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverage or entitlements. It is your responsibility to confirm the accuracy of statements made by the Plan or the Plan's designees, including the Claims Administrator, in accordance with the terms of the Plan.

Information and Records

At times the Plan Administrator or the Claims Administrator may need additional information from you. You agree to furnish the Plan and/or the Claims Administrator with all information and proofs that the Plan Administrator or the Claims Administrator may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when it is requested it may cause the Plan to delay or deny payment of your benefits. By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan or the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan Administrator or the Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons,

including enrolled Dependents whether or not they have signed the Participant's enrollment form. The Plan Administrator and the Claims Administrator agree that such information and records will be considered confidential.

The Plan Administrator and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator or the Claims Administrator is required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, the Plan Administrator and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements the Plan Administrator recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms. If you request medical forms or records from the Plan, the Plan also may charge you reasonable fees to cover costs for completing the forms or providing the records. In some cases, the Plan Administrator or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

In the event of a question or dispute regarding your right to benefits, the Plan may require that a Network Physician of our choice examine you at the Plan's expense, when and so often as it may reasonably be required, and the Plan has the right to require an autopsy in case of death where it is not prohibited by law.

Subrogation and Right of Refund

The Plan is governed by Federal law (the Employee Retirement Income Security Act of 1974 ("ERISA")). Under ERISA, Plan fiduciaries have a duty to maximize reimbursements from Covered Persons, including exercise of subrogation and the right of refund. "Subrogation" means the Plan's right to pursue the claims of you and your enrolled Dependents, for charges paid by the Plan, against another person, entity or organization, and/or your or their insurer. "Refund" means repayment to the Plan for benefits that it has advanced toward care and treatment of you and your enrolled Dependents. The Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has advanced, or will advance, payments for charges, and any costs and fees associated with the enforcement of its rights under the Plan.

You and your enrolled Dependents must repay the Plan out of any recovery related to the injury, sickness or pregnancy for which benefits are advanced by the Plan. Your enrolled Dependents are third party beneficiaries of the Plan. This means that they are parties to the contract between you and the Plan, and are also subject to this provision including the obligation to repay the Plan.

Condition of Participation

As a condition of participating in the Plan, you and your enrolled Dependents must recognize the Plan's right to subrogation and refund. These rights provide the Plan with a priority over any funds (regardless of whether such funds fully or partially compensate you for your losses) paid by any party or any insurance company to you and your enrolled Dependents relative to an injury or sickness for which benefits are advanced by the Plan, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. In other words, the make-whole doctrine shall not apply. As an additional condition of participation, you and your enrolled Dependents agree to hold in trust for the Plan's benefit under these subrogation provisions any and all proceeds of settlement or judgment.

Assignment of Rights

Accepting payments advanced under this Plan for medical or dental expenses automatically assigns to the Plan any rights you or an enrolled Dependent may have to recover payments for those expenses from any party and any insurer. This subrogation right allows the Plan to pursue any claim which, in the opinion of the Plan Administrator, you or your enrolled Dependent may have against any party and/or any insurer, whether or not you and/or your enrolled Dependents choose to pursue that claim.

Lien

The Plan may make a claim directly against any party and/or insurer, but in any event, the Plan has a lien on any amount recovered by you and/or your enrolled Dependents whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full. Battelle and the Plan Administrator reserve the right to reduce any future benefit payments for you and/or your enrolled Dependents until the obligation to reimburse the Plan is satisfied.

Requirement of Cooperation/Completion of Subrogation Form

When in the opinion of the Plan Administrator, a right of subrogation and/or refund exists, you and/or your enrolled Dependent (as applicable) will be required to execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan advance payments. Claims related to the Injury or Sickness may be suspended until the subrogation forms provided by the Claims Administrator have been properly completed, signed and returned. In addition, you and/or your enrolled Dependents, as applicable, agree to do nothing to prejudice the right of the Plan to subrogate. You and your enrolled Dependents agree not to accept any settlement that does not fully compensate or reimburse the Plan without first acquiring the Plan's written approval of such settlement.

The Plan's right of subrogation and refund applies to all types of recoveries, including (but not limited to) insurance payments even if it is from your own insurance, reimbursements, cash payments and monies paid by way of judgment, settlement, or to reflect charges covered by the Plan.

This right of subrogation and refund also applies when you and/or your enrolled Dependents are entitled to recover under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Attorney's Fees

The Plan shall not share the costs of, or pay any part of, the attorney's fees and costs of you and/or your enrolled Dependents, incurred in obtaining any recovery against the person, entity or organization causing the Injury, or its insurer. Additionally, the Plan reserves the right to recover reasonable attorney fees from you and your enrolled Dependents that are incurred while collecting proceeds subject to these subrogation provisions.

Refund of Overpayments

If the Plan pays benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the benefits under the Plan.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested as a condition of participation in this Plan.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Indemnification

Battelle or the Plan may indemnify, through insurance or otherwise, any one or more of the fiduciaries with respect to the Plan against any claims, losses, expenses, damages, or liabilities arising out of the performance (or failure of performance) of their responsibilities under the Plan.

Governing Law

This Plan shall be construed in accordance with the laws of the State of Ohio, except where such laws are superseded by ERISA or the Internal Revenue Code in which case ERISA or the Internal Revenue Code shall control.

Invalidity of Certain Provisions

In the event any provisions of this Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of this Plan and this Plan shall be construed and enforced as if such illegal and invalid provisions had never been inserted herein.

Limitation of Action

If you want to bring a legal action against us, the Plan or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us, the Plan or the Claims Administrator.

You cannot bring any legal action against us, the Plan or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us, the Plan or the Claims Administrator you must do so within three years of the date you are notified of the Plan's final decision on your appeal or you lose any rights to bring such an action against us, the Plan or the Claims Administrator.

Disagreement with Recommended Treatment

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

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

Circumstances Beyond the Control of the Plan

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. A complete description of your rights under HIPAA will be found in the Plan's privacy notice, which will be distributed to you upon enrollment and will be available from the Plan Administrator.

The Plan and the Plan Sponsor will not use or further disclose health information that is protected by HIPAA except as necessary for treatment, payment, health plan operations and Plan administration functions, or as otherwise permitted or required by law. The Plan will not, without authorization, use or disclose protected health information for employment related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor except as permitted between plans that are part of an Organized Health Care Arrangement under HIPAA's privacy rule.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. The Plan's privacy notice will provide a greater description of your rights and the Plan's obligations under the HIPAA privacy rule.

As a Claims Administrator of your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the customer service number on the back of your Identification Card.

Participants Right to Receive a Certificate of Health Coverage

If your coverage under this plan stops, you and your enrolled Dependents will receive a certificate that shows your period of health coverage under the plan. You may need to furnish the certificate

if you become eligible under another group health plan if it excludes coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependents may also request a certificate within 24 months of losing coverage under this Plan.

Coordination of Benefits

Applicability

This provision applies when you have health care coverage under more than one Plan. For the purposes of this provision, "Plan" is defined below.

If this provision applies, the Order of Benefit Determination Rules specify whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. Will not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan; but
2. May be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The reduction is described under the heading "Effects on the Benefits of this Plan."

Definitions

Plan - this Plan and any other arrangement providing health care or benefits for health care through:

1. Group insurance or group-type coverage whether insured or uninsured. This includes prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Individual insurance for individual-type coverage. This includes prepayment, group practice, or individual practice coverage.
3. Coverage under a governmental Plan or coverage required or provided by law except Medicare or Medicaid.
4. Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee Plan, a union welfare Plan, an employee organization Plan or an employee benefit organization.
5. Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

"Plan" is not any of the following:

1. Group or group-type Hospital indemnity benefits of \$100.00 per day or less.
2. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis.

Primary Plan/Secondary Plan - the Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered a benefit paid.

Order of Benefit Determination Rules

Certain governmental plans, such as Medicaid and TRICARE, are always secondary by law. Except as required by law, Medicare supplement plans and other plans that don't coordinate benefits at all must pay as if they were primary.

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee or Participant (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that: if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - a. Secondary to the Plan covering the person as a Dependent; and
 - b. Primary to the Plan covering the person as other than a Dependent (e.g. a retired

employee),

Then the order of benefits is reversed so that the Plan covering the person as an employee, Participant, or Retiree is secondary and the other Plan is primary.

2. Dependent Child/Parents not Separated or Divorced. Except as stated in paragraph 3. below, when this Plan and another Plan cover the same child as a Dependent of different parents who are not separated or divorced:
 - a. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; if (1) the parents are married; (2) the parents are not separated (whether or not they ever have been married); or (3) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage; but
 - b. If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in subsection a. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the Plan of the parent with custody of the child;
 - b. Then, the Plan of the Spouse of the parent with custody of the child;
 - c. Then, the Plan of the parent not having custody of the child; and
 - d. Finally, the Plan of the Spouse of the non-custodial parent.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent will be the Secondary Plan. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's Spouse does, the Spouse's Plan is primary. This subclause does not apply to any Plan year during which any benefits are actually paid or provided before the entity has actual knowledge.

4. Joint Custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of

the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.

5. **Active/Inactive Participant.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.
6. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
 - a. First, the benefits of a Plan covering the person as an employee, Participant or as that person's Dependent;
 - b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered the person longer are determined before those of the Plan which covered that person for the shorter term. If none of the preceding rules determines the Primary Plan, the benefits paid shall be shared equally between the Plans.

Effect on this Plan's Benefits

When a Covered Person 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, if necessary, by the combined benefits of all other Plans covering you or your Dependent that pay prior to this Plan under those Rules.

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.

Note: There is no secondary coverage on prescription drugs.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The 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.

Coordination of Benefits with Medicare

Any Benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Medicare is a secondary payer to an employer's group health plan for up to 30 months for beneficiaries who have Medicare solely because of permanent kidney failure. At the end of the 30-month period, Medicare becomes the primary payer until your Medicare coverage for permanent kidney failure ends. For further information check with your nearest Social Security office or the Medicare insurance carrier in your area.

This Plan reduces its benefits for Participants and Enrolled Dependents who are eligible for Medicare when Medicare would be the primary coverage.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B. As a result, the person will be responsible for the costs that Medicare would have paid and will incur a larger out-of-pocket cost.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B. When we are the secondary payer, we will pay any benefits available under the Plan as if the person had followed all rules of the Medicare+Choice Plan. The person will be responsible for any additional costs or reduced benefits that result from failure to follow these rules, and will incur a larger out-of-pocket cost.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules. As a result, the person will be responsible for the costs that

Medicare would have paid and will incur a larger out-of-pocket cost.

- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare. Accordingly, the person will be responsible for the costs that Medicare would have paid and will incur a larger out-of-pocket cost.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B. Therefore, the person will be responsible for the costs that Medicare would have paid and will incur a larger out-of-pocket cost.

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Covered Persons are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Covered Person shall be reimbursed by, or on behalf of, the Covered Person 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 Workers' Compensation.

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 Covered Persons 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.

Unclaimed Funds

If a benefit payment or an administrative expense check is not cashed within a reasonable period of time, as determined by the Plan Administrator, the check shall be voided and shall be used to reduce future contributions by Battelle. However, if the payee later makes a proper claim to the Plan for the amount, it shall be restored to the trust fund by Battelle and paid to the payee in accordance with the terms of the Plan.

Relationship of Parties (Employer-Covered Person-Administrator)

Neither the Employer nor any Covered Person is the agent or representative of the Claims Administrator.

The Employer is fiduciary agent of the Covered Person. The Claims Administrator's notice to the Employer will constitute effective notice to the Covered Person. It is the Employer's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Covered Persons if the Employer fails to provide the Claims Administrator with timely notification of Covered Person enrollments or terminations.

Policies and Procedures

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Covered Person shall comply.

Waiver

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

COMPLAINT AND APPEALS PROCEDURES

The Claims Administrator's customer service representatives are specially trained to answer your questions about your health benefit Plan. Please call during business hours, Monday through Friday, with questions regarding:

- your coverage and benefit levels, including Copayment amounts;
- specific claims or services you have received;
- doctors or Hospitals in the Network;
- referral processes or authorizations; and/or
- Provider directories.

A complaint procedure has been established to provide fair, reasonable, and timely review of complaints that you may have concerning the Plan. The Claims Administrator invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by medical Providers in the Claims Administrator's Networks.

The Complaint Procedure

If you have a complaint, problem, or claim concerning benefits or services, please contact the Claims Administrator. Please refer to your Identification Card for the Claims Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Claims Administrator of its procedures and contracts. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint. If your complaint involves issues of Covered Services, you may be asked to sign a medical records release form so the Claims Administrator can request medical records for its review.

The Appeals Procedure

How To Appeal A Denial Of Eligibility Or Enrollment

The Plan provides one level of appeal for eligibility or enrollment determinations. If you believe you should be covered under the Plan, but your eligibility or enrollment has been denied, then you may appeal that denial. You must mail a written request for a review (appeal) to the Plan Administrator within 180 days after your receipt of such denial. Your appeal should include an explanation of the reasons you believe you should be eligible to participate in the Plan. Your request will be provided a full and fair review by the Plan Administrator or its delegate, and you

will be notified of the decision in writing within a reasonable period of time, not to exceed 30 days after the Plan Administrator's receipt of your appeal. Your appeal for eligibility or enrollment may also qualify as a Pre-Service, Urgent Care or Concurrent Care claim which may shorten the time period during which the Plan Administrator may respond.

Your written request for an **eligibility or enrollment appeal** should be sent to:

**Plan Administrator
Battelle Memorial Institute
505 King Avenue
Columbus, OH 43201-2693**

How To Appeal A Claim Decision

As a Covered Person of the Plan, you have the right to appeal decisions to deny or limit the Plan benefits. You may also file an appeal to address concerns regarding confidentiality or privacy. Appeals should be filed with the Claims Administrator for review in accordance with the procedures set forth below.

Prescription Drug Appeals

For most prescription drug claims, the Plan only offers one level of appeal. However, for prescription claims that were denied through the CVS Caremark Specialty Guideline Management program, there are 2 levels of appeal. A prescription drug appeal should include a copy of the denial notice, a copy of the denial letter, an explanation of why the initial claim denial should be reversed, and a copy of any information that will support your request.

You or your eligible Dependent(s) may send a written request for a Level 1 prescription drug appeal to the address below for prescription drug claims, other than those denied through CVS Caremark's Specialty Guideline Management program. Your request must be received within 180 days after receiving the initial notice of denial. The Plan Administrator will respond to your appeal within 30 days from the date of receipt of your appeals request.

**Plan Administrator
Battelle Memorial Institute
505 King Avenue
Columbus, OH 43201-2693**

If you are appealing an adverse Specialty Guideline Management decision, you may request that the decision be reviewed by submitting a Level 1 appeal in writing to the address below, within 180 days after receiving the notice of denial.

**CVS Caremark
Appeals Department
MC109, P.O. Box 52084
Phoenix, AZ 85072-2084**

The Claims Administrator (CVS Caremark) will respond to your appeal within 30 days from the date of receipt of your appeals request. If your appeal is in response to a decision that was based, in whole or in part, on clinical judgment, your appeal will be reviewed by an appropriate clinical professional. If your appeal is denied, you will receive a denial letter, which will include the reasons for the decision, references to the plan provisions on which the decision was based and instructions for a Level 2 appeal.

If you are dissatisfied with CVS Caremark's Level 1 appeal decision, you may submit a written request for a Level 2 appeal to the Plan Administrator at the address below. Please note that Level 2 appeals must be filed within 180 days of receipt of notice of the Level 1 appeal determination. The Plan Administrator will respond to your appeal within 30 days from the date of receipt of your appeals request.

**Plan Administrator
Battelle Memorial Institute
505 King Avenue
Columbus, OH 43201-2693**

Medical Appeals

A medical appeal is a request from you for the Claims Administrator to change a previous determination made. An initial determination by the Claims Administrator can be appealed for further review by the Claims Administrator at two subsequent levels known as "Level 1" and "Level 2" appeals. The Claims Administrator will advise you of your rights to the next level of review if a denial is upheld after a Level 1 appeal or a Level 2 appeal.

You have the right to designate a representative (e.g. your Physician) to file an appeal on your behalf and to represent you in the appeal. If a representative is seeking an appeal on your behalf, the Claims Administrator must obtain a signed Designation of Representation form from you before the Claims Administrator can begin processing your appeal unless a Physician is requesting expedited review of a Level 1 appeal on your behalf. If that occurs, the Physician will be deemed to be your representative for the purpose of filing the expedited Level 1 appeal without receipt of a signed form.

Once an appeal has been filed as described below, the Claims Administrator will accept oral or written comments, documents or other information relating to the your appeal from you, your designated representative or your Provider by telephone, facsimile or other reasonable means. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to your appeal.

Level 1 Appeals

Level 1 appeals are reviewed by a person who did not make the initial determination and who is not the subordinate of the initial reviewer. If a clinical issue is involved, the Claims Administrator will use a clinical peer for this review unless your appeal concerns an adverse voluntary predetermination decision or unless the adverse decision can be overturned based upon

prescreening by a nurse or other qualified reviewer. A clinical peer is a physician or Provider who has the same license as the Provider who will perform or has performed the service.

If your Level 1 appeal concerns an adverse Precertification decision, your appeal may be initiated by letter or over the phone. The Claims Administrator requires its Covered Persons to submit all other requests for appeal in writing. Written appeal requests, including a detailed description of the problem and all relevant information, should be sent to the address below or to the address (or phone number for adverse Precertification decisions) provided for filing an appeal on any written notice of an adverse decision that you receive from the Claims Administrator.

Attention: Appeals
Anthem Blue Cross and Blue Shield
P. O. Box 33200
Louisville, KY 40232-3200

If you are appealing an adverse Precertification decision (i.e., an adverse Prospective, Concurrent or Retrospective review decision) or the denial of any prior approval required by the Plan, the Claims Administrator will provide you with a written response indicating the Plan's decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days after the date the Claims Administrator receives your Level 1 appeal request. If more information is needed to make a decision on your appeal the Claims Administrator will send a written request for the information after receipt of the appeal. No extensions of time for additional information may be taken on these Level 1 appeals without the permission of the Covered Person. Therefore, the Claims Administrator will make a decision based upon the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision and sufficient information is available to decide the appeal, the Claims Administrator will resolve your Level 1 appeal within a reasonable period of time but not later than 30 calendar days from receipt of the Level 1 appeal request. If more information is needed to make a decision on your appeal, the Claims Administrator shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 calendar days of the Level 1 appeal request, the Claims Administrator shall conduct its review based upon the available information, which review shall be completed within a reasonable period of time but not later than 40 calendar days from receipt of the Level 1 appeal request. After the Level 1 appeal decision is made, you will be notified within 5 calendar days in writing by the Claims Administrator of the Plan's decision concerning your Level 1 appeal.

In no event will notice of the decision on appeal be sent to you more than 60 calendar days after receipt of your appeal.

Level 2 Appeals

If you are dissatisfied with the Level 1 appeal decision, you may request a Level 2 appeal. At Level 2, the appeal is reviewed by a panel of the Claims Administrator's staff members. You

have a right to personal appearance before the Level 2 appeals panel. Level 2 appeals concerning adverse Precertification decisions or the denial of any prior approval required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Level 2 appeal request was received by the Claims Administrator. All other Level 2 appeals will be resolved by the panel no later than 45 business days from the date your Level 2 appeal request was received by the Claims Administrator. After the appeal panel makes a decision you will be notified within 5 business days in writing by the Claims Administrator of the Plan's decision concerning your Level 2 appeal.

Expedited Reviews

Any level of appeal can be expedited if:

- The service at issue has not been performed;
- The service at issue has been denied as Experimental/Investigative or as not Medically Necessary; and
- Your Physician believes that the standard appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

The Claims Administrator by applying a prudent lay person standard, may also determine that an appeal may be expedited.

The Claims Administrator will complete expedited review of a Level 1 appeal as soon as possible taking into account the medical urgency of the situation but not later than forty-eight hours (48 hours) after the Claims Administrator receives the Level 1 appeal request and will communicate the Plan's decision by telephone to your attending Physician or the ordering provider. The Claims Administrator will also provide written notice of the Plan's determination to you, your attending Physician or ordering provider, and the facility rendering the service. The Claims Administrator will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and panel administration permits. The Plan's decision will be communicated by telephone to your attending Physician or the ordering provider. The Claims Administrator will also provide written notice of the Plan's determination to you, your attending Physician or ordering provider, and to the facility rendering the service.

External Appeals

If you are dissatisfied with the Plan's Level 2-appeal decision, an "External Appeal" may be available. External Appeal is available if a service or supply has been denied as Experimental/Investigative. The External Appeal option also extends to services denied as not Medically Necessary if the cost of the medical service is over \$10,000 or if the service at issue has not been received and non-receipt of the medical service would jeopardize the patient's life or health. It is coordinated by the Claims Administrator and involves a review of the case by an independent reviewer. External Appeal is available after all other appeal rights with the Claims

Administrator are exhausted. In a case of urgently needed care, the Claims Administrator may elect to bypass some levels of appeal to send a case directly to an External Appeal. An External Appeal is not available for services or supplies that are limited or excluded by contract.

Appeals Filing Time Limit

You are encouraged to file Level 1 appeals on a timely basis. The Claims Administrator will not review a Level 1 appeal if it is received after 180 calendar days since the participant received the notice of denial. Level 2 appeals must be filed within 60 days of receipt of notice of the Level 1 appeal determination. An External Appeal, must be filed within 60 days from receipt of the Plan's Level 2-appeal decision.

Appeals by Covered Persons of ERISA Plans

You are covered under an Employer Plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Therefore, you must file a Level 1 appeal prior to bringing a civil action under 29 U.S.C. 1132 §502(a). Level 2 appeals and External Appeals, if available, are voluntary levels of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be temporarily suspended while a Level 2 appeal or External Appeal, if available, is pending. You will be notified of your right to file for a voluntary level of review if the Plan's response to your current appeal level (i.e., Level 1 or Level 2 appeal) is adverse. Upon your request, the Claims Administrator will also provide you with detailed information concerning Level 2 appeals and, if available, External Appeals, including how Level 2 panelists are selected.

ERISA INFORMATION

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

Plan Name: Medical Plan for BMI Retirees (commonly known as The Blue Cross Blue Shield Network Only Medical Plan for Retirees and Dependents not eligible for Medicare)

Plan Sponsor: Battelle Memorial Institute

Type of Plan: Group Health Plan – Exclusive Provider Organization

Type of Administration: Third Party Administration

Plan Administrator: Battelle Memorial Institute

Plan Administrator's Name, Address and Phone Number: Battelle Memorial Institute
Attn: Malesa A Litteral, Esq.
505 King Avenue
Columbus, Ohio 43201-2693
(614) 424-6350

Employer Identification: 31-4379427

Plan Number: 539

Agent for Services of Legal Process of the Plan: Battelle Memorial Institute
Attn: Daniel O. Cecil, Esq.
505 King Avenue
Columbus, Ohio 43201-2693

Service of legal process may be made upon the Plan Administrator.

Fiduciary: Battelle Memorial Institute

Plan Modification and Amendment: Battelle President, CEO or Board

Funding: Self-Insured

End of Plan Year: 12-31

Name of Claims Administrator: Community Insurance Company (Anthem)

Claims Administrator's Address and Phone Number: Anthem BCBS
P.O. Box 37010
Louisville, KY 40233-7010
Customer Service: 1-800-514-3021

STATEMENT OF ERISA RIGHTS

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

- **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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 Claims 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 the Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- **Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another group health Plan**

You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage. To request a certificate of creditable coverage, you should contact the COBRA Coordinator at (614) 424-6172 or mail to:

Battelle
Attn: COBRA Coordinator
505 King Ave, Room: A-1-86
Columbus, OH 43201

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

- **Assistance with Your Questions**

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

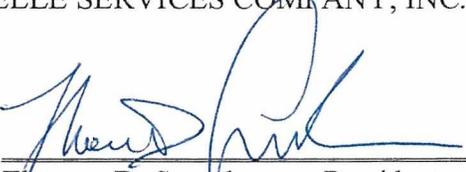
As evidence of its adoption of the Battelle Blue Cross Blue Shield Network Only Medical Plan for BMI Retirees not eligible for Medicare, Battelle Memorial Institute has caused this instrument to be signed by its President or designated officer this 22 day of JANUARY, 2010 but effective as of January 1, 2010.

BATTELLE MEMORIAL INSTITUTE

By: 

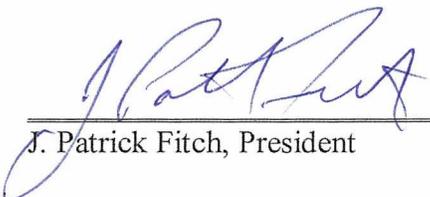
Thomas D. Snowberger, Sr. V.P.
Human Resources

BATTELLE SERVICES COMPANY, INC.

By: 

Thomas D. Snowberger, President

BATTELLE NATIONAL BIODEFENSE INSTITUTE, LLC

By: 

J. Patrick Fitch, President

