

COLLABORATIVE SETTLEMENT AGREEMENT

The City of Cincinnati (“City”), the Cincinnati Retirement System (“CRS”), Mayor John Cranley (“Mayor”), City Manager Harry Black (“City Manager”); Nick Sunyak (“Sunyak”) Jeffery Harmon (“Harmon”), Jill Allgeyer (“Allgeyer”), Kim Kappel (“Kappel”), Waleia Jackson (“Jackson”), Finley Jones (“F. Jones”), and Richard Ganulin (“Ganulin”), individually and on behalf of the classes and sub-classes of current City employee plaintiffs later defined herein; Thomas A. Gamel, Sr., (“Gamel”), Paul Smith (“Smith”), Mark K. Jones (“M. Jones”), Dennis Davis (“Davis”), Ely Ryder (“Ryder”) and Ann DeGroot (“DeGroot”), individually and on behalf of the class of intervening City retiree plaintiffs later defined herein; and the American Federation of State and Municipal Employees Ohio Council No. 8 (“AFSCME”) (“the Parties”) do hereby enter into this Collaborative Settlement Agreement (“Agreement” or “Collaborative Agreement”) on May 7, 2015. This Collaborative Agreement constitutes a full and complete settlement of any and all claims asserted against the City, the CRS and related City Defendants, or that could have been asserted, in consideration of the mutual promises of the Parties and pursuant to the terms and conditions set forth below, all subject to the approval of the Court.

INTRODUCTION

The Parties have litigated complex questions about the management of the CRS – and the respective rights of plan participants – for nearly five years. This litigation has addressed, *inter alia*, benefits levels, eligibility requirements, healthcare benefits and funding mechanisms. While some of these lawsuits have been subject to conclusive appellate rulings, many pertinent legal and factual questions remain. In past years, each new set of proposed CRS reforms have invited a new round of legal challenges – including, but not limited to, questions of procedural and substantive due process as raised by both current employees, future retirees and current retirees.

EXHIBIT

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The Parties have concluded that continued litigation would be wasteful and counterproductive. Any dispositive rulings on the pending issues would likely take years to achieve – years during which the CRS’ accruing unfunded liability would continue to grow and the City’s bond rating may become ever more endangered. Given these facts, the Parties determined it was in their best interests and the public interest to craft a collaborative mediation process in which all issues relating to the CRS are addressed. These efforts culminated in the terms of this Collaborative Agreement.

VALUE STATEMENT

This Collaborative Agreement represents a sincere effort to “share the pain” of complex and much-needed pension reforms. It is the product of many months of cooperative, collaborative and iterative negotiations amongst the City, representatives of employees, a labor union which represents many of them, and representatives of City retirees.

The reforms promulgated in this Collaborative Agreement constitute a comprehensive strategy to stabilize the CRS while also securing sustainable and competitive retirement benefits for both current and future City retirees. The terms of this Collaborative Agreement will greatly improve the City’s long-term financial position and will meaningfully address concerns regarding the City’s creditworthiness as determined by both governmental entities and national credit rating agencies.

GOALS OF COLLABORATIVE SETTLEMENT AGREEMENT

While this Agreement primarily addresses the accruing unfunded liability that has destabilized the CRS during the past decade, its overall goals go far beyond actuarial calculations. The Parties acknowledge that years of poor communication among the various stakeholders has created suspicion and occasional animosity. This contentious atmosphere has often rendered substantive discussions impossible. Thus, this Agreement addresses both

material issues within the CRS and the less tangible (but equally important) issues of trust, access and transparency that have long hampered reform efforts. Accordingly, the Parties have adopted the following overarching goals in regards to the structure and implementation of this Agreement:

- First Goal: Stabilize the overall financial position of the CRS so that both current and future retirees can expect to receive meaningful and competitive benefits in the future, specifically pension, including a Cost of Living Adjustment (“COLA”), and healthcare benefits.
- Second Goal: The pension trust fund will be funded at actuarially appropriate levels, with the goal of establishing a projected 100 percent funding ratio in 30 years, and will remain so funded for the balance of this Agreement, pursuant to its terms and provisions.
- Third Goal: The trust fund for healthcare benefits is to be funded at actuarially appropriate levels sufficient to provide the healthcare benefits set forth herein for the remaining term of this Agreement, subject to the terms of this Agreement.
- Fourth Goal: Reduce the CRS’s accruing unfunded liability so that national credit rating agencies and state agencies will no longer threaten the City with potentially devastating downgrades directly related to such liability.
- Fifth Goal: Set forth a long-term plan to ensure the provision of pension benefits for future generations of City employees, while also maintaining flexibility to address unexpected market downturns and upturns as well as new opportunities. Specifically, the City must be able to consider and respond to possible merger opportunities with other large public retirement systems. The City must also retain its ability to adapt to changes in the healthcare marketplace, especially those changes precipitated by federal law.
- Sixth Goal: Retirees have made irrevocable elections of retirement benefits, expecting the City to guarantee those promised benefits, and thus understandably seek stability in those benefits. They must have confidence that those retirement benefits will be funded by the City and that the City will not ignore its funding commitment for those benefits. They must also have confidence that neither the City nor the other Parties will attempt to alter these benefits outside of the parameters set forth in this Agreement.
- Seventh Goal: Increase the transparency of CRS-related decisions so that both current and future retirees may better understand and exercise their collective rights as members of the system.

Further, this Agreement will resolve the issues raised by the various pending complaints and motions for preliminary injunction, as well as the pending writ of mandamus filed by AFSCME on behalf of its Cincinnati-area members in the Hamilton County Court of Common Pleas.

The Parties, their agents, successors and all persons in active concert or participation with any of them shall abide by the terms of this Agreement. It is understood and agreed that the terms and implementation of this Agreement are not intended to (and shall not be construed to) violate the terms of any collective bargaining agreement by and between the City and any other entities representing employees of the City. Additionally, it will not include any terms and conditions of employment that must be negotiated by and between the City, the Parties and any other such representative entities.

The Parties also acknowledge that asset performance and the macro-economic environment are beyond the control of the CRS stakeholders and the Court.

JURISDICTION

This Collaborative Agreement memorializes the terms by which the Parties fully and finally resolve the allegations and claims set forth in two consolidated cases pending before the Honorable Michael R. Barrett in the United States District Court for the Southern District of Ohio: (1) *Sunyak v. City of Cincinnati*, Case No. 1:11-cv-445; and (2) *Harmon v. City of Cincinnati*, Case No. 1:12-cv-329. In addition, this Agreement fully and finally resolves the allegations and claims set forth in the litigation titled *State ex rel. Council 8 AFSCME, et al. v. City of Cincinnati, et al.*, Case No. A 1104791, pending before the Hamilton County Court of Common Pleas.

Central to this Agreement is the Consent Decree which is attached hereto as Exhibit 1 and which fully incorporates by reference the terms of this Agreement. The Consent Decree establishes that the Court shall retain jurisdiction over the implementation, interpretation, administration, and enforcement of this settlement following the Effective Date.

The Parties agree that, after Finality, they will: (1) dismiss with prejudice the claims asserted in the Actions; and (2) approve the terms and conditions of this Agreement and the related Consent Decree, such that these Actions and the claims shall be finally and fully resolved, settled, and compromised based upon and subject to the terms and conditions set forth both in this Agreement and attached Consent Decree.

DEFINITIONS

Wherever used in this Agreement and the attached Consent Decree, the following boldface terms have the meanings specified below:

“115 Trust Fund” means the fund to be created under Section 115 of the United States Internal Revenue Code and those funds to be held in trust and invested for the sole purpose of funding secured health care benefits for eligible retired members of the CRS.

“401(h) Account” means the funds presently held and invested for the purpose of funding retirees’ medical benefits.

“Actions” or **“Litigation”** mean the following cases now pending: *Sunyak v. City of Cincinnati*, Case No. 1:11-cv-445 (S.D. Ohio); *Harmon v. City of Cincinnati*, Case No. 1:12-cv-329 (S.D. Ohio); and *State ex rel. Ohio Council 8 AFSCME, et al. v. City of Cincinnati, et al.*, Case No. A 1104791 (Hamilton County Ohio Court of Common Pleas).

“**AFSCME**” means the plaintiff in the litigation titled *State ex rel. Council 8 AFSCME, et al. v. City of Cincinnati, et al.*, Case No. A 1 104791, pending before the Hamilton County Ohio Court of Common Pleas.

“**Class Counsel**” means Current Employees Class Counsel and Retirees Class Counsel.

“**Class Member(s)**” means an individual who is either a Current Employees Class member or a Retirees Class member.

“**Class Notice**” or “**Notice**” means the settlement notice set forth below, the text of which shall be substantially similar to the notice attached hereto as Exhibit 2.

“**Classes**” means the Current Employees Class and the Retirees Class.

“**COLA**” means cost of living adjustment to a pension annuity payment.

“**Consent Decree**” means the decree to be entered, a copy of which is attached hereto as Exhibit 1.

“**Court**” means the United States District Court for the Southern District of Ohio, Western Division, which is presiding over this settlement and the *Sunyak* and *Harmon* actions.

“**Covered Payroll**” means the annual amount of pensionable salaries for full-time employees who are members of the CRS. The City represents and warrants that this amount has been employed in the actuarial calculations referenced throughout this Agreement, including, but not limited to, the calculation of the City’s Annual Contribution. This definition only applies to the terms and provisions of this Agreement.

“**CRS**” means the Cincinnati Retirement System.

“**CRS Pension Trust Fund**” means those funds to be held in trust and invested for the purpose of funding benefits, other than medical benefits, for the CRS.

“Current Employees Class” means the approximately 2,900 current City employees (approximately 2,400 are employed as of the date of this Agreement) defined as follows: All individuals who participated in the CRS with at least five years of creditable service and who were actively employed or otherwise qualified for benefits on July 1, 2011, and who are members of Group C, Group D, Group E, or Group F as these terms are defined by Cincinnati Municipal Code (“CMC”) §203-1-MI (b), (c), (d), and (e). The Current Employees Class also includes the Dependents and/or the Surviving Beneficiaries of any Current Employees Class member who are entitled to the retirement benefits which are the subject of this Agreement and Consent Decree. As detailed below in the subclass descriptions, members of the Current Employees Class have experienced significant increases in their pension contributions, reductions in their eventual retirement benefits, extensions of the years of work required to be eligible for unreduced pension benefits, and significant increases in current healthcare costs during their employment, including an increase of more than 100 percent in their premiums in recent years.

“Current Employees Class Counsel” means Marc D. Mezibov, Esq., Robert D. Klausner, Esq., Christian A. Jenkins, Esq., and Jeffrey S. Goldenberg, Esq.

“Current Employees Class Representatives” mean the Current Employees Plaintiffs designated in this document.

“Defendants” or **“City Defendants”** mean the Defendants in any of the Actions who are: (1) the City, (2) the Mayor, (3) the City Manager, (4) the Vice-Mayor, (5) the City Council Members, (6) the CRS; and (7) the Board of Trustees of the CRS (“Board”).

“Defendants’ Counsel” means Steven P. Goodin, Esq. and John Pinney, Esq. (and the law firm of Graydon Head and Ritchey, LLP) and the City Solicitor for the City of Cincinnati, Paula Boggs Muething.

“Dependents” means spouses and eligible dependent children and orphans of members of the Current Employees Class and the Retirees Class.

“Effective Date” or **“Effective Date of the Settlement”** means the day after which all of the following events have occurred: (1) this Settlement Agreement is fully executed by all the Parties; (2) the Court enters the Preliminary Approval Order as set forth below; and (3) the Court enters the Order Granting Final Approval as set forth below.

“Fairness Hearing” means the hearing before the Court at which time the Court considers:

- (1) Whether this Agreement, including the Exhibits to this Agreement, should be approved as fair, adequate, and reasonable;
- (2) Whether an Order Granting Final Approval as set forth below should be entered;
- (3) Whether the applications of Class Counsel for payment of attorneys’ fees, costs and expenses should be approved; and
- (4) Any other matters addressed by the Court, including any objections properly raised by Class Members.

“Finality” means: (1) If no timely appeal has been taken from the Order Granting Final Approval, the day after the day on which all periods of time for any Party or Class Member to appeal have expired; or (2) If any timely appeal is undertaken, the day after the day on which any such appeal shall have been fully resolved, the Final Order shall have been affirmed in all

material respects, and no further appeal to, or discretionary review remains in any court (whether by expiration of the time for any further appeal or otherwise).

“Funded Ratio” means the actuarial value of assets divided by the actuarial accrued liability at a given period in time.

“Group C Sub-Class” means the Current Employees Class members who are also members of Group C.¹ The Group C Sub-Class is represented by Jill Allgeyer. The adoption and enforcement of Ordinance No. 84-2011 negatively impacted members of Group C because they no longer would receive a death benefit of at least \$5,000.

“Group D Sub-Class” means the Current Employees Class members who are also members of Group D.² The Group D Sub-Class is represented by Kappel, Jackson, and Ganulin. The adoption and enforcement of Ordinance No. 84-2011 negatively impacted members of Group D because they no longer receive a death benefit of at least \$5,000 and a three percent COLA compounded annually. Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent. Members of Group D who did not retire on or before January 1, 2014 were automatically assigned to Group E.

“Group E Sub-Class” means the Current Employees Class members who are also members of Group E.³ The Group E Sub-Class is represented by F. Jones. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group E no longer receive a death benefit of at least \$5,000, a three percent per year COLA compounded annually, and a retirement benefit amount calculated based on the highest 36 months final average salary with a

¹ CMC §203-1-MI (c) defines Group C as those employees who had at least 30 years of service credit before July 1, 2011, or who were at least 60 years old with 5 years of service credit before July 1, 2011.

² CMC §203-1-MI (d) defines Group D as those employees who have at least 30 years of service credit by December 31, 2013, or employees who reach age 60 with at least 5 years of service credit by December 31, 2013.

³ According to the CMC §203-1-MI (e), Group E consists of those employees originally assigned to Group D who did not retire on or before January 1, 2014.

2.22 percent or 2.5 percent multiplier applicable to all years of creditable service ("Higher Benefit Amount"). Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent and replaced the Higher Benefit Amount with a less generous formula to calculate the benefit accrued from January 1, 2014 until retirement - limiting the multiplier applicable to such years to two percent for years over 30 years of service and 2.2 percent for all other years after January 1, 2014 and using the highest 60 months final average salary for years after said date.

"Group F Sub-Class" means the Current Employees Class members who are also members of Group F.⁴ The Group F Sub-Class is represented by Sunyak and Harmon. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group F no longer receive the Higher Benefit Amount, and the right to retire with unreduced benefits upon reaching 30 years of service - regardless of age. Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent, replaced the Higher Benefit Amount with a new formula to calculate the benefit accrued from July 1, 2011 until retirement - limiting the multiplier for years after July 1, 2011 to 2.2 percent for years of service up to 30 and two percent for years of service over 30. It also used the highest 60 months final average salary for years after July 1, 2011, and replaced the 30 years of service requirement with a requirement that such employees also must be 60 years of age to receive full unreduced benefits.

"Higher Benefit Amount" means a death benefit of at least \$5,000, a three percent COLA compounded annually, a retirement benefit amount calculated based on the highest 36

⁴ The Current Employees Class only includes those members of Group F who had at least 5 years of creditable service on July 1, 2011 and who were not assigned to Group C, D, or E.

months' salary with a 2.22 percent or 2.5 percent multiplier applicable to all years of creditable service.

"Notice Date" means the first day on which the Notices are mailed.

"Notice Program" means the process by which information about this Settlement shall be made available to the Current Employees Class members and the Retirees Class members as set forth below.

"Order Granting Final Approval" or **"Final Order"** means the Order from the Court granting final approval to this Settlement and ordering that this Court retain jurisdiction over the administration, enforcement, and interpretation of this settlement pursuant to and consistent with the Consent Decree.

"Ordinance No. 84-2011" means City Ordinance No. 84-2011 which became effective on July 1, 2011.

"Ordinance No. 85-2011" means City Ordinance No. 85-2011 which became effective on July 1, 2011.

"Original Plaintiffs" or **"Current Employees Plaintiffs"** mean the following plaintiffs in the *Sunyak* and *Harmon* cases: (1) Sunyak, (2) Harmon, (3) Allgeyer, (4) Kappel, (5) Jackson, and (6) Ganulin, each of whom were active City employees at the time the *Sunyak* and *Harmon* cases were filed. Current Employees Plaintiffs also include F. Jones, who is to be added as a party to this litigation pursuant to the Preliminary Approval Order.

"Parties" mean: (1) the Current Employees Plaintiffs; and (2) the Current Employees Class, (3) the Retiree Plaintiffs; (4) the Retirees Class; (5) AFSCME; and (6) the Defendants.

"Plaintiffs" mean the Current Employees Plaintiffs, the Retiree Plaintiffs, and AFSCME.

“Preliminary Approval Date” means the date on which the Court enters the Preliminary Approval Order.

“Preliminary Approval Order” means the Order from the Court granting preliminary approval to this Settlement.

“Retiree Plaintiffs” mean the following retirees who initially filed a Motion to Intervene in the *Sunyak* and *Harmon* cases on March 17, 2014: Gamel, Beets, Smith, M. Jones, Davis, Ryder, and DeGroot.

“Retirees Class” means the approximately 4,400 individuals formerly employed by the City of Cincinnati, the University of Cincinnati, the University Hospital f/k/a General Hospital and Hamilton County, who retired on or before July 1, 2011 and have received retirement benefits from the City and their Dependents and/or their Surviving Beneficiaries who are entitled to those benefits. Pursuant to the adoption and enforcement of Ordinance No. 84-2011 and Ordinance No. 85-2011, members of the Retirees Class no longer receive a death benefit of \$7,500, having been reduced to \$5,000, no longer receive premium-free healthcare separately identified as a benefit on documents signed by retirees upon retirement and which premiums totaled as much as \$1,125 in 2014, no longer receive dental and vision insurance coverage both of which premiums totaled \$875 in 2014, no longer receive reimbursement for Medicare premiums of over \$1,200 per year (over \$2,400 per year including spouse), have a smaller healthcare provider network and many no longer qualify for “carve-out” benefits owing to a more stringent criteria. Members of the Retirees Class and their beneficiaries lost over an estimated \$4,000 per capita per year in healthcare benefits as a result of benefit reductions imposed in 2010 through 2012. Additionally, Members of the Retirees Class are prepared to sacrifice an additional \$2,800 per capita per year in pension in order to gain long-term stability

in healthcare benefits which had been reduced. These costs have been and will be imposed on retirees whose average pension is \$35,000. Further, other Retirees Class benefits have been threatened by the huge growth in CRS unfunded liabilities, which is a result, in part, of the City's failure to contribute to the CRS Pension Fund in accordance with the funding formula set forth in §203-93 CMC. The Retirees Class is also concerned about the potential loss of their Death Benefits of \$5,000 per retiree.

"Retirees Class Counsel" means Robert A. Pitcairn, Jr., Esq., James F. McCarthy, III, Esq., Peter J. O'Shea, Esq. and the law firm of Katz, Teller, Brant & Hild.

"Retirees Class Death Benefit" A lump sum of \$5,000 available only to the members of the Retirees Class in accordance with the provisions of CMC § 203-47, in effect January 1, 2015.

"Retirees Class Healthcare Benefits" means those benefits provided by the CRS to the Retirees Class. The benefits include: (1) the specific benefits described in the Medical Benefits Booklet for City of Cincinnati Retirees administered by Anthem, effective January 1, 2014, subject to the limitations and exclusions, copayments, deductibles and coinsurance requirements specified in that booklet (a copy of that booklet is attached as Exhibit 3); (2) the "exclusion approach," as used in 2014, for the coordination of Medicare benefits; (3) Rx formulary as administered in 2014 by Optum (and as set forth on the Optum website at www.optumrx.com);⁵ (4) the limitations, exclusions, copayments, deductibles and coinsurance requirements as prescribed in the contract by and between the City and Optum in effect in 2014 (a copy of that agreement is attached as Exhibit 4); (5) Rx Coach program which provides no-copay prescriptions for lipids reduction, high blood pressure regulation, and diabetes control for patients who participate in provider counseling programs; (6) no lifetime limit on benefits; (7) all

⁵ Members must create an account to sign into the website. Once logged in, members should select the link titled "Formulary" to view the list of approved drugs. A hard copy of the Formulary for December 31, 2014 shall be retained by Retirees Class Counsel.

“preventative health care” and “essential health care” benefits, as mandated by the State of Ohio or the federal government; and (8) such treatment and formularies which are generally accepted best medical practices. This definition is subject to the terms of this Agreement.

“Retirees Class Representatives” mean the Retiree Plaintiffs as identified in this document.

“Settlement Administrator” means the entity responsible for issuing notice to Current Employees Class and the Retirees Class.

“Settlement Date” means the date on which this Agreement becomes fully executed by all the Parties.

“Settlement Website” means the Internet website described herein.

“Surviving Beneficiaries” means spouses and eligible dependent children and orphans of members of the Current Employees Class and the Retirees Class.

“Tax Receipts” means the gross annual amount of funds collected by the City from all taxes, income and property.

GENERAL ALLEGATIONS PROVIDING CONTEXT FOR SETTLEMENT

Generally, the Original Plaintiffs allege in their Amended Consolidated Complaint that the Defendants unlawfully revoked and impaired their vested retirement benefits by adopting and enforcing Ordinance No. 84-2011.

The Original Plaintiffs seek declaratory and injunctive relief for themselves and all others similarly situated who participated in the CRS and had earned or purchased as provided in this Agreement at least five years of creditable service prior to July 1, 2011, and who are members of Group C, Group D, Group E or Group F as these Groups are defined by Cincinnati Municipal Code § 203-1-MI(b), (c), (d), and (e).

Allgeyer is a member of Group C. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group C no longer receive a death benefit of at least \$5,000. Allgeyer will represent the Group C Sub-Class of the Current Employees Class.

Kappel, Jackson, and Ganulin are members of Group D. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group D no longer receive a death benefit of at least \$5,000 and a three percent COLA compounded annually. Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent. Members of Group D who did not retire on or before January 1, 2014 were automatically assigned to Group E. Kappel, Jackson and Ganulin will represent the Group D Sub-Class of the Current Employees Class.

F. Jones is a member of Group E. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group E no longer receive the Higher Benefit Amount. Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent and replaced the Higher Benefit Amount with a less generous formula to calculate the benefit accrued from January 1, 2014 until retirement – thus limiting the multiplier applicable to such years to 2.2 percent up to 30 years and two percent for each year of service accrued thereafter. F. Jones will represent the Group E Sub-Class of the Current Employees Class.

Sunyak and Harmon are members of Group F. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group F no longer receive the Higher Benefit Amount, and the right to retire with unreduced benefits upon reaching 30 years of service - regardless of age. For Group F, Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent, replaced the Higher Benefit Amount with a

less generous formula to calculate the benefit accrued from July 1, 2011 until retirement - limiting the multiplier to 2.2 percent for years of service up to 30 and two percent for years of service over 30 and using the highest 60 months final average salary, and replaced the 30 years of service requirement with a requirement that such employees also must be 60 years of age to receive unreduced benefits. Sunyak and Harmon will represent the Group F Sub-Class of the Current Employee Class.

Generally, the Retiree Plaintiffs allege that the City has already unilaterally and significantly curtailed retiree health benefits and threatened and continues to threaten to further suspend or significantly curtail retiree health benefits, reduce the Retiree Plaintiffs' COLA from the current three percent compounding COLA with a simple indexed COLA not to exceed two percent, and to suspend the COLA for a period of years.

Pursuant to the adoption and enforcement of the Ordinance No. 84-2011 and Ordinance No. 85-2011, Members of the Retirees Class no longer receive a death benefit of \$7,500, having been reduced to only \$5,000, no longer receive premium-free healthcare separately identified as a benefit on documents signed by retirees upon retirement and which premiums totaled as much as \$1,125 in 2014, no longer receive premium-free dental and vision insurance coverage both of which premiums totaled \$875 in 2014, no longer receive reimbursement for Medicare premiums of over \$1,200 per year (over \$2,400 per year including spouse), have a smaller healthcare provider network and many no longer qualify for "carve-out" benefits owing to more stringent criteria. Members of the Retirees Class and their beneficiaries estimate their losses to be over \$4,000 per capita per year in healthcare benefits as a result of benefit reductions imposed in 2010 through 2012. Additionally, Members of the Retirees Class are prepared to sacrifice an additional estimated \$2,800 per capita per year in pension in order to gain long-term stability in

healthcare benefits which had been reduced. These costs have been and will be imposed on retirees whose average pension is \$35,000. Further, other Retirees Class benefits have been threatened by the huge growth in CRS unfunded liabilities, which is a result, in part, of the City's failure to contribute to the CRS Pension Fund in accordance with the funding formula set forth in §203-93 CMC. The Retirees Class is also concerned about the potential loss of the Retiree's Class Death Benefit. These concerns are based upon numerous communications from and discussions with City officials.

The Members of the Retirees Class are also concerned that the adjudication of the Original Plaintiffs' claims in the Amended Consolidated Complaint will prejudice them by "adversely affecting" the financial viability and ability of the CRS to pay benefits, and that any settlement related to the Original Plaintiffs' Amended Consolidated Complaint could prejudice the Retirees Class Members' ability to independently assert their claims at a later date. The Plaintiffs are also concerned that, in the absence of a global resolution, the CRS Pension Fund, which is approximately 36 percent underfunded as of December 31, 2013, is likely to be unable to pay out future benefits. Consequently, the City is likely to eliminate or substantially modify and/or further reduce the retirement benefits.

AFSCME, which represents approximately 1,800 current employees of the City, filed an action in mandamus in the Hamilton County Court of Common Pleas alleging that the City failed to adequately fund the CRS in violation of the terms of the Cincinnati Municipal Code. AFSCME and its members are concerned that the adjudication or settlement of the Original Plaintiff's claims in the Amended Complaint will prejudice them by adversely affecting the City's ability to adequately fund the CRS and to pay future benefits to AFSCME's members. AFSCME's members are also concerned that in the absence of a global settlement and with any

continued underfunding of the CRS, the City would face fiscal challenges in balancing the General Fund and in the downgrading of the City's bond rating that would result in reduction or loss of City services, layoffs, increased employee benefit and CRS contributions and/or reduced health care benefits.

The City contends that it faces several imminent fiscal and regulatory challenges that require immediate action to stabilize the CRS. These challenges include, but are not limited to, the following:

- i. The ongoing negative impact on the City's general obligation bond rating if the City cannot reduce or eliminate the CRS' accruing unfunded liability;
- ii. The concern that the Ohio Auditor could place the City on fiscal caution, watch, or emergency pursuant to relevant provisions of the Ohio Revised Code;
- iii. The concern that the CRS Pension Fund has an unfunded liability in excess of \$829 million and is only 63.2% funded as of December 31, 2013; and
- iv. Contemplated legislation in the Ohio General Assembly, which if approved, will require pension systems in the State to be 100% funded within a 30-year period.

The City thus contends that it is in a position of substantial fiscal challenge which may adversely affect its long-term ability to sustain the CRS.

Further, recent jurisprudence involving retiree healthcare, including but not limited to *M&G Polymers USA, LLC v. Tackett*, 574 U.S. ____ (2015), may limit the ability of the Retirees Class to effectively litigate their rights to any such benefits. Moreover, recent jurisprudence has failed to provide clarity about common law and statutory entitlement to set COLA levels and

other retirement benefits. Thus, there is risk to all Parties concerning the possible result of continued litigation. The Parties agree that a judicially-supervised collaborative resolution of these issues is in the best interest of the Parties.

CLASS CERTIFICATION

The Parties agree that the goal of securing the implementation of the terms of this Agreement shall be accomplished through certification of plaintiff class actions (and related subclasses) under Fed. R. Civ. P. 23(b)(1)(a), 23(b)(1)(b) and 23(b)(2) covering the Classes. The Original Plaintiffs shall serve as class representatives of the Current Employees Class and the Retiree Plaintiffs shall serve as class representatives of the Retirees Class. The Parties acknowledge that AFSCME members are included within the Current Employees Class and related sub-classes. The Parties agree to the certification of the mandatory Classes for settlement purposes only under Fed. R. Civ. P. 23(b) subject to the Court's approval.

The Parties agree that they are entering into this Agreement for settlement purposes only. Any acquiescence or agreement to the class certification in this case does not constitute an admission of liability or fault by the City, the City Defendants, or any of their officials, agents, or employees, and may not be used as evidence in any proceeding by any member of the Classes except proceedings under this Agreement and the related Consent Decree. Further, by agreeing to class certification for settlement purposes only, the Parties agree that any resulting classes or sub-classes do not constitute classes or sub-classes in other proceedings. The City agrees to be responsible for the issuance of any notices to interested parties required to implement this Agreement. The City agrees to pay any costs associated with such notice(s) including the cost to engage the Settlement Administrator.

CLASS COUNSEL

The following are hereby designated class counsel by agreement of the Parties subject to the final approval of the Court pursuant to Rule 23(g): (1) Christian A. Jenkins, Esq., Minnillo & Jenkins, Co. LPA, 2712 Observatory Avenue, Cincinnati, Ohio 45208; Marc D. Mezibov, Esq., Law Office of Marc Mezibov, 401 E. Court Street, Suite 600, Cincinnati, OH 45202; Jeffrey S. Goldenberg, Esq., Goldenberg Schneider, LPA, One West Fourth Street, 18th Floor, Cincinnati, Ohio 45202; and Robert D. Klausner, Esq., Klausner, Kaufman, Jensen & Levinson, 7080 Northwest Fourth Street, Plantation, FL 33317 and shall serve as the Current Employees Class Counsel; and (2) Robert A. Pitcairn, Jr., Esq., James F. McCarthy, III, Esq., Peter J. O'Shea, Esq., and the law firm of Katz Teller Brant & Hild, 255 East Fifth Street, Suite 2400, Cincinnati, Ohio, 45202 shall serve as the Retirees Class Counsel.

The Parties do hereby stipulate that the Current Employees Class Counsel and the Retirees Class Counsel are competent to handle the matters described herein and have relevant experience in same. None face any disqualifying conflict of interest or ethical duty and undertake such duties with full knowledge of all attendant obligations and responsibilities.

OTHER PARTIES' COUNSEL

For the purposes of the execution of this Agreement only, R. Sean Grayson, Esq., AFSCME, Ohio Council 8, 6800 North High Street, Worthington, OH 43085-1918, shall serve as counsel for AFSCME and Steven P. Goodin, Esq. and John B. Pinney, Esq., Graydon Head, 1900 Fifth Third Center, 511 Walnut Street, Cincinnati, OH 45202, of counsel to City Solicitor Paula Boggs Muething, shall serve as counsel for the City and all City Defendants.

OPERATIVE SETTLEMENT TERMS

The Parties agree, stipulate and warrant to the following terms of settlement:

1. CRS Funds: All funds held in the CRS Pension Trust Fund shall be used solely for the benefit of the members of the CRS.⁶

2. CRS Pension Trust Fund: The funds held in the CRS Pension Trust Fund shall be subject to this Agreement and the following: (1) all funds held and invested are to pay retirement benefits, excluding healthcare benefits; (2) the funds shall not be subject to the claims of creditors; (3) the City may not grant any security interest or creditor interest in the CRS Pension Trust Fund; (4) the board of trustees of the CRS may not grant any security or creditor interest in the funds held in the CRS Pension Trust Fund; and (5) upon agreement of the Parties or by order of the Court, expenses and fees outlined in this Agreement may be paid from funds in the CRS Pension Trust Fund.

3. 115 Trust Fund: The City shall create a 115 Trust Fund prior to the Effective Date for the purpose of holding and investing funds to provide Retirees Class Healthcare Benefits, Current Employees Class Healthcare upon Retirement and healthcare benefits upon retirement to members of the CRS as provided pursuant to the CMC, subject to the terms and conditions in this Agreement. The City shall be obligated to fund the 115 Trust Fund at actuarially appropriate levels sufficient to provide these benefits for the term of this Agreement. The funds held in the 115 Trust Fund shall be subject to this Agreement and the following: (1) the funds held and invested are to pay Retirees Class Healthcare Benefits, Current Employees Class Retirement Healthcare Benefits and retiree healthcare benefits for any eligible City employees; (2) the funds shall not be subject to the claims of creditors, except as may be required by the terms of this Agreement; (3) the City may not grant any security interest or

⁶ This Agreement shall not bind the Defendants or the CRS regarding individuals not covered by this Agreement. Subject to applicable law and collective bargaining rights, the City retains the exclusive authority to set benefit levels for those current and future employees who are not subject to this Agreement.

creditor interest in the 115 Trust Fund; and (4) the board of trustees of the CRS may not grant any security or creditor interest in the funds held in the 115 Trust Fund.

4. Transfer of Funds to the 115 Trust Fund: The City shall transfer from the CRS 401(h) account to the 115 Trust Fund such funds as may be required to fund healthcare benefits at actuarially appropriate levels sufficient to provide the healthcare benefits set forth herein for the term of this Agreement. The Parties will allow a reasonable period to complete this transaction, with the understanding that those funds will likely be unavailable for transfer until the 401(h) liabilities have been paid out.

5. Projected Healthcare Savings Applied to Pension: The Defendants shall apply at least \$200 million but not more than \$220 million from the 401(h) Account to the CRS Pension Trust Fund to reduce its unfunded liability. Any savings from the healthcare modifications must be realized consistent with the projections outlined in the Cavanaugh MacDonald report attached as Exhibit 5 and must allow the 115 Trust Fund to remain at actuarially appropriate levels sufficient to provide the benefits.

6. Retirees Class and Current Employees Class Rights: All members of the Current Employees Class and the Retirees Class have guaranteed rights in their pension, including COLA, and healthcare benefits, subject to the terms and provisions of this Agreement and the Consent Decree.

7. CRS COLA Calculation: Effective January 1, 2016 or the Effective Date, whichever is later, the COLA for current and future retirees in the Current Employees Class and the Retirees Class, except as provided in this Agreement, will be a three percent fixed simple adjustment⁷ (as opposed to the three percent compounded COLA currently received by most

⁷ The simple three percent COLA will be applied on the anniversary date as follows: Assume a retiree has an annual pension of \$10,000 per year. The three percent COLA is equal to \$300. Each succeeding COLA amount is

members of the Retirees Class and the simple COLA indexed to inflation not to exceed two percent currently applicable to most members of the Current Employees Class). Until such time, the Retirees Class and current and future retirees in the Current Employees Class shall receive the COLA, compounded or simple, to which they were entitled as part of their pension pursuant to the terms of the CMC as of December 31, 2014. For those Members who retired prior to July 1, 1987, the new COLA calculations will commence on January 1, 2016. For those Members who retired on or after July 1, 1987, the new COLA calculations will commence on their retirement anniversary date, subject to the rights of Current Employees Class Members to receive payments under Paragraph 16 below as if said COLA was in effect at the time of their retirement.

8. CRS Retirees' Class COLA: The basis for the calculation of the simple COLA set out in Paragraph Seven for Members of the Retirees Class will be the gross monthly pension payment payable on January 1, 2016 but shall include all previously granted COLAs and the compounded COLA earned in 2015.

9. Current Employees Class COLA Delay Period: Each Current Employees Class member shall be subject to a three-year COLA delay period during which he or she will not receive a COLA. For those members of this Class yet to retire, the three-year COLA delay period begins on the one-year anniversary date following their date of retirement. These individuals shall not receive a COLA in their second, third and fourth years of retirement, but shall receive a COLA in all years after their fourth year of retirement. For those members of this Class who retired after July 1, 2011 and on or prior to January 1, 2016, the three-year COLA

aggregated with the prior COLA payment. In the first year in which a COLA is applied, the annual benefit would be \$10,300. The next COLA payment of \$300 would take the annual benefit to \$10,600. The third COLA payment of \$300 would take the annual amount to \$10,900. This process would continue on an annual basis.

delay period begins to run on their next retirement anniversary date or on January 1, 2016, whichever is later.

10. Retirees Class COLA Suspension Periods: Beginning January 1, 2016, or January 1 of the year following the Effective Date, no Member of the Retirees Class shall be entitled to a simple COLA for a period of three years except as provided elsewhere in this Agreement. The suspension period shall commence upon January 1, 2016, or the anniversary date of the individual member's retirement, whichever date is later, pursuant to the applicable provisions of the Cincinnati Municipal Code effective December 31, 2014. Members of the Retirees Class shall receive a one-time payment calculated at three percent of their base pension annuity benefit (but in any event, capped at \$1,000) at the commencement of the third year of their respective COLA suspension period.

11. COLA Poverty Exception: Any member of the Retirees Class or the Current Employees Class (or their surviving dependent entitled to continuing CRS benefits) who retired (or retires) with at least five years of creditable service and whose household income is below 150% of the U.S. Department of Health and Human Service's updated annual poverty guideline pursuant to 42 U.S.C. 9902(2) will receive the above-referenced three percent compounding COLA without being subject to any COLA delay or suspension. If for that year and any subsequent year their household income (as defined in CMC § 203-44) exceeds 150 percent of the federal poverty guidelines, these retirees will receive the three percent simple COLA described above, after appropriate notice has been provided to the qualifying retirees.

12. Current Employees Class Retirement Eligibility: Current Employees Class members can retire with unreduced pension benefits pursuant to the terms of this Agreement upon reaching 30 years of service or at age 60 with five years of service.⁸

13. Retirement Benefit Multiplier Calculation: When calculating a retirement benefit for a Current Employees Class Member, the CRS administrator shall utilize a 2.5 percent multiplier⁹ for the greater of: (a) 20 years of service or (b) the number of years of service prior to July 1, 2011 for Current Employees Class members in Group F and the number of years of service prior to January 1, 2014 for Current Employees Class members in Group E. A 2.2 percent multiplier shall be used for all other years of service unless a higher multiplier would apply under Ordinance No. 84-2011, in which case such higher multiplier shall apply. The Parties agree that the two percent multiplier for years of service in excess of 30 as provided by Ordinance No. 84-2011 shall be superseded by the foregoing multipliers.

14. Final Average Salary Calculation: The Final Average Monthly Salary ("FAS") component used to calculate the pension benefits of members of the Current Employees Class upon their retirement shall continue to be determined in the same manner as it has been for each respective class since adoption of Ordinance No. 84-2011. Specifically, this means that: (1) Members of Group C and D will have an FAS based on their highest 36 months of service including pensionable lump sum payout for 2.22 percent members; and (2) Group E will have an FAS with two separate components based upon: a) years of service through December 31, 2013,

⁸ Those employees who are veterans shall be permitted to purchase service credit for their years of active duty military service prior to July 1, 2011 in accordance with existing CRS policies. Any service credit purchased in this manner will count toward obtaining five years of creditable service prior to July 1, 2011 thereby enabling veterans to vest for purposes of the benefits afforded under this Agreement regardless of when purchased or otherwise accrued.

⁹ Those Class Members who previously elected to utilize a 2.22 percent multiplier for all earnings during the applicable years, including without limitation overtime hours, shall be subject to the 2.22 percent multiplier in the same manner as the 2.5 percent multiplier under this provision.

on the highest 36 consecutive months of earnings during entire membership in CRS from first day of membership through last day of paid employment; and b) years of service on and after January 1, 2014, on the highest consecutive 60 months of earnings during entire membership in the CRS; and (3) Group F will have an FAS based upon the following two components: a) for years of service through June 30, 2011, on the highest 36 consecutive months of earnings during entire membership in CRS from first day of membership through last day of paid employment; and b) for years of service after June 30, 2011 on the highest consecutive 60 months of earnings during entire membership in CRS.

15. Early Retirement Eligibility: The following Early Retirement Eligibility changes shall occur for the benefit of the Current Employees Class members: (1) the age 57 and 15 years of service requirement formula established Ordinance No. 84-2011 shall be superseded by the terms of this Agreement; and (2) the age 55 and 25 years of service requirement that existed prior to Ordinance No. 84-2011 shall be reinstated; and (3) the retirement option for those employees who reach age 60 and have at least five years of service that existed prior to Ordinance No. 84-2011 shall be reinstated.

16. Annuity Adjustments: The pension annuity benefits for Current Employees Class members in Groups D and members of Groups E and F who retire before January 1, 2016, or the Effective Date, whichever is later, will be adjusted prospectively by being increased to the amount that their benefits would have been had the Consent Decree been in effect on the date of their retirement. In addition, these Current Employees Class members will receive a payment designed to compensate for the difference between the amount of pension benefits they received from the date of their retirement until the effective date of the Agreement and the amount they would have received had the Agreement been in effect on the date they retired. These payments

shall be made no later than 120 days after the Effective Date of the Agreement. Current Employees Class Counsel shall be entitled to review and confirm that these payments are accurate and in compliance with this provision prior to these payments being issued.

17. Employee Contributions: Pension contributions made by Current Employees Class members shall not exceed nine percent of pensionable wages during the term of the Consent Decree, subject to this Agreement and the Consent Decree. Any reduction in pension contributions may not adversely affect benefits as defined in this Agreement for members of the Classes.

18. Group C Settlement Payment and Retirement Healthcare Benefits: Because members of the Group C Sub-Class, upon their retirement, would have been entitled to a three percent compounding COLA from July 1, 2011 until January 1, 2016,¹⁰ or the Effective Date, whichever is later, they shall receive a one-time Group C Settlement Payment pursuant to the following schedule to be paid no later than 90 days after the Effective Date of this Agreement or within 90 days following the member's retirement, if later:

- i. Retired after July 1, 2011 through December 31, 2011: \$125
- ii. Retired on or after January 1, 2012 through December 31, 2012: \$250
- iii. Retired on or after January 1, 2013 through December 31, 2013: \$375
- iv. Retired on or after January 1, 2014 through December 31, 2014: \$500
- v. Retired on or after January 1, 2015 or remained employed by the City as of the effective date of the Consent Decree: \$625

In addition, notwithstanding any language in this Agreement to the contrary, all members of Group C, including both those who have retired prior to the Effective Date and those who have

¹⁰ Members of the Group C Current Employee Sub-Class were entitled to retire with full benefits (other than the retirement death benefit) as of July 1, 2011 but remained employed by the City.

not, shall be entitled to Retirees Class Healthcare Benefits on the same terms as members of the Retirees Class, including specifically but not limited to continued eligibility for retiree health benefits with 15 years of creditable service. The City renders no opinion, and accepts no liability, in regards to any tax consequences related to such payments.

19. City's Annual Contribution to CRS Pension Trust Fund: The City shall contribute to the CRS Pension Trust Fund no less than 16.25 percent of Covered Payroll annually for the duration of the Consent Decree (30 years) notwithstanding any contrary calculations claimed by any Party or non-party under any provision of the CMC or any other basis.

20. Additional Contributions to CRS Pension Trust Fund:

- i. The City, recognizing the risk typically borne by the employer in a defined benefit plan, shall contribute to the CRS Pension Trust Fund an additional three percent of Covered Payroll for three consecutive years before requesting an Annual Minimum Funded Ratio Re-opener as defined in Paragraph 35 (iii) of this Agreement. Following that three-consecutive-year supplemental contribution, the City may seek an Annual Minimum Funded Ratio Re-opener only if the City complies with the requirements of the Annual Minimum Funded Ratio Re-opener set forth in Paragraph 35 (iii) for the term of this Agreement.
- ii. If the City sells an asset or privatizes any City service or otherwise transfers or loses a City function which results in a reduction of total Covered Payroll, the City shall provide or secure funding for any remaining pension and healthcare liabilities to remedy any impact on the CRS.

- iii. Recognizing the need for additional cash contributions, the City shall make an additional contribution equal to or greater than the remaining liability on the Early Retirement Incentive Program (ERIP) through a judgment or settlement bond with the consent of the Parties and the Court or continue current required payments.

21. Deferred Retirement Option Plan ("DROP"): Beginning with the completion of 30 years of creditable service, Current Employees Class members may effectively retire and freeze their accrual of years of service in the CRS plan and defer receipt of retirement benefits, including health care benefits for retirees, for a period not to exceed five years while continuing City employment. Current Employees Class members will be subject to the COLA delay period set forth in Paragraph 9 at the close of their individual DROP periods, and shall not be paid COLAs during the DROP period. The deferred pension benefits of DROP participants shall accumulate during their participation in the DROP in an individual account together with any individual employee contributions during such period. All amounts credited to individual DROP accounts shall be 100 percent vested in such individuals and shall not be subject to forfeiture under any circumstances. Such amounts shall experience earnings but in no event less than zero percent per year. At or before the end of the five-year deferral period, such employees must separate from service. The deferred amount either must be distributed or rolled over into a qualified account within 120 days of said separation from service. The DROP program shall be cost neutral to the CRS Pension Trust Fund and shall not negatively impact the CRS Funded Ratio and may be primarily administered by a third party entity. If insurance coverage for the CRS to guard against negative performance can be obtained on reasonable terms, the City shall acquire such coverage at the expense of each DROP participant. If such insurance is not

available, the City shall assess reasonable and sufficient fees, payable from each DROP account, to insure against negative performance and to cover the cost of administration and expenses to the CRS. The Parties agree to facilitate an independent actuarial analysis of the DROP during the fifth year of its implementation. If, based upon that analysis, the program is not cost-neutral to the CRS Pension Trust Fund, the Parties shall then submit the matter to the Court for possible reformation or closure of the DROP, as warranted by the facts and determined by the Court to assure the DROP is cost neutral, provided that any individual who has entered the DROP shall be entitled to participate in the DROP for five full years. The establishment of the DROP is a material element of the Settlement for both the Current Employees Class and AFSCME. Any dispute over the terms, conditions and administration of the DROP shall be referred to the Court for resolution.

22. Retirees Class Healthcare Benefits: For each year following the Effective Date, co-pay, deductibles and out of pocket amounts shall not increase for the term of this Agreement. The premiums charged shall be five percent of the CRS healthcare costs for the previous year, net of copays, deductibles, and out of pocket expenses paid by retirees.

23. Current Employees Class Retirement Healthcare Benefits: Current Employees Class members shall be entitled to retirement healthcare benefits as provided in this Agreement if they retire with at least 30 years of creditable service regardless of age, or at or after age 60 with at least 20 years of creditable service (except for members of Group C, who shall be entitled to the same retirement healthcare benefits as members of the Retirees Class if they retire with at least 15 years of creditable service). These Current Employees Class members shall receive the most favorable plan available to active employees (excluding police and fire) at the time of their respective retirements.

24. Current Employees Class Retirement Healthcare Premium Percentages¹¹:

- i. Pre January 9, 1997 Hire Date: Current Employees Class members hired prior to January 9, 1997 shall pay the same percentage of premium for retiree healthcare benefits as paid by active employees at the time of their retirement. However, in no event shall these Current Employees Class members pay greater than 10% of their premium.
- ii. January 9, 1997 or later Hire Date: Current Employees Class members hired on or after January 9, 1997 shall pay the percentage of premium for retiree healthcare benefits according to a revised Point System to be negotiated which will address the perceived inequities in the current Point System. For example, under the current Point System (attached as Exhibit 8) a Current Employees Class member retiring with 30 years of service at age 59 would pay 25% of the premium, whereas a Current Employees Class member retiring with 30 years of service at age 60 would pay only 5% of the premium. The goal of such negotiations between the Parties will be to provide retiree healthcare benefits at a cost of 10% of the premium to as many future retirees as possible without reducing the funding ratio of the 115 Trust Fund below actuarially appropriate levels and cost neutral to the 115 Trust Fund. If the Parties cannot agree to a framework for such reforms within six months of the Effective Date, then the matter shall be submitted to the Court for a final resolution and/or determination. If this issue is submitted to the Court, the Court shall not increase any Current Employees Class Member's premium percentages beyond those contained in the Point System as of January 1, 2015 and the Court cannot alter the funding ratio of the 115 Trust Fund

¹¹ Pursuant to Paragraph 18 above, the provisions set forth in Paragraph 24 do not apply to Group C.

below actuarially appropriately levels or materially increase costs to the 115 Trust Fund.

25. Healthcare Modifications for Retirees: To be effective January 1 of the year following the Effective Date, the City shall:

- i. Establish an Employer Group Waiver Plan (“EGWHP”) to maximize prescription-drug-related reimbursements from federal healthcare programs. The EGWHP will provide substantially similar benefits to the Retirees Class Healthcare Benefits;
- ii. Implement a voluntary, medical expense reimbursement program (“MERP”); and
- iii. Alter retirement health care eligibility requirements for members of the Current Employees Class in accordance with this Agreement.¹²

26. Healthcare Funding Obligation: The City shall develop and present to the Parties a proper funding policy for the 115 Trust Fund no later than 30 days prior to the Fairness Hearing. The funding policy will satisfy all consent decree requirements including but not limited to the City’s obligation to fully fund the 115 Trust at actuarially appropriate levels for the term of this Agreement.

27. Retirees Class Death Benefit: The Retirees Class Death Benefit shall be paid to the designated beneficiaries of the members of the Retirees Class who will be entitled to a Retirees Class Death Benefit.

28. Consent Decree Duration: The Consent Decree shall remain in force for 30 years from the Effective Date.

¹² This provision is not applicable to members of Group C who will receive benefits as set forth in the other applicable provisions of this Agreement.

29. Assumed Rate of Return: A 7.5 percent annual assumed rate of return shall be applied to any and all actuarial calculations related to the valuation of the CRS Pension Trust Fund and the 115 Trust Fund for purposes of this Agreement.

30. Pension Board Reforms: The Parties agree to negotiate in good faith reforms for the administration of the CRS including the composition of the Board of Trustees and the administration of the CRS. If the Parties are unable to reach agreement on such reformation within 120 days of the execution of this Agreement, the Court shall determine the composition, structure and function of the Board. In such an event, the Parties agree that the Court will honor the following parameters:

- i. A Board of Trustees shall be established. The Board shall have nine members. Four members shall be appointed by the Mayor, three members shall be elected by retired members and two members shall be elected by employee members. The Board is subject to and bound by the terms and provisions of this Agreement.
- ii. The Mayor's appointees shall be made with input from City Council and subject to any subsequent ordinances adopted by City Council.
- iii. The members shall elect a chair and vice-chair who shall each serve two-year terms. The chair (or vice-chair in the absence of the chair) shall be responsible for communicating the concerns of the Board to the CRS administrator, setting Board meeting agendas and, after consulting with the board as a whole, establishing priorities for the CRS administrator (Director of Retirement Department) and CRS staff.
- iv. The Board shall administer the CRS for the benefit of the members of the CRS. The Board shall have the exclusive authority to administer the CRS Pension Trust

Fund and the 115 Trust Fund, subject to the terms and provisions of this Agreement and the Cincinnati Municipal Code, provided that, in the event of any conflict, this Agreement and Consent Decree shall control. Each member of the Board shall have fiduciary responsibility as defined under the laws of the State of Ohio. The fiduciary responsibility shall be solely to the active and retired members of the CRS.

- v. The City Manager shall be the appointing authority for the Director of the Retirement Department and shall supervise his or her performance. The Board will actively participate in any searches for a new Director, whether by committee or otherwise, and may present candidates for consideration. The City Manager and the Board shall develop formalized procedures for the evaluation of the Director and the Board's annual written evaluation of the Director's performance shall be submitted to the City Manager at the close of each fiscal year. The City Manager may also dismiss the Director if warranted by circumstances and performance. The City Manager shall dismiss the Director of the Retirement Department at the request of a two-thirds majority of the Board of Trustees.
- vi. The Board will follow the City's established procurement process for its selecting and contracting with any actuaries, investment advisors and other professionals deemed necessary for the administration of the CRS. Any investment manager(s) and firms hired shall be experienced and reputable professionals in the field. They shall have experience and competencies in the areas of management of funds for large public pension plans. They shall be experienced in assessing index funds, assessing, comparing, choosing and administering appropriate asset

allocation plans, and satisfying objectives. Any firm(s) chosen shall also have records of achievement regarding integrity and attaining plan goals. The term of investment firm and manager contract(s) shall be two years, with two additional two year extensions, for a maximum term of six years. Prior to the end of the six-year term, these contractual services must be rebid, but nothing herein is intended to preclude selection of the former contractor.

- vii. The Board may determine the format and content of any reports from the actuary and investment managers. However, the Board shall not limit, in any way, the right and duty of the actuary or investment manager(s) to provide content deemed by the actuary or investment manager(s) to be important for the Board, the members, staff and public. All reports shall be provided to the members of the Board, and members of the Board may request additional reports as needed.
- viii. Any deposits, expenditures, transfers, loans, or withdrawals for the CRS Pension Trust Fund, the 115 Trust Fund, or staff funds that were not identified in the annual budgets must be approved by a vote of two-thirds of the members present. All such actions shall be included and identified as a line item in the budget which shall be approved annually by the board by a two-thirds vote of those present. The payment of attorneys' fees and expenses as approved by the Court pursuant to this Agreement is not subject to this provision.
- ix. Board and committee meetings shall be considered meetings of a public body and be open to the public subject to lawfully convened executive sessions.

31. No Disgorgement: Neither as a result of this Agreement nor the related Consent Decree shall any retirement benefit being received by any retiree be reduced. Likewise, no

retiree shall be required to repay or otherwise disgorge any amounts received from the CRS after the Effective Date as a result of this Agreement. The City reserves the right to attempt to recoup overpayments made due to administrative error.

32. Actuarial Confirmation: The City shall provide to the Current Employees Class Counsel, the Retirees Class Counsel and Counsel for AFSCME confirmation of the actuarial data utilized during the mediation process. Any dispute as to whether confirmation of this actuarial data has occurred shall be resolved by the Court no later than 30 days prior to the Fairness Hearing. The City shall also provide, as requested by Current Employees Class Counsel, the Retirees Class Counsel and Counsel for AFSCME other information related to class membership, pension statistics, or other similar data or information to facilitate final approval of this Settlement. Any dispute as to whether confirmation of this actuarial data has occurred shall be resolved by the Court no later than 30 days prior to the Fairness Hearing.

33. Contingency and Lack of Severability: Given the unique nature of this Agreement and Consent Decree and the interlocking nature of their terms, the Parties hereby expressly agree that the terms and provisions set forth in this Agreement and Consent Decree are contingent upon one another. The reforms contained herein are cumulative, iterative and based upon actuarial projections, and must be enforced *in toto*.

34. Attorney's Fees: The Parties agree that Current Employees Class Counsel and Retirees Class Counsel may submit an application for an award of attorneys' fees to the Court no later than twenty-one days prior to the deadline for Class Members to object to the terms of the Settlement Agreement. Attorneys' fees and expenses awarded by the Court shall be paid within 20 business days following the Effective Date. Defendants and Current Employees Class Counsel further agree and stipulate that any class counsel fees associated with representation of

the Current Employees Class will be ultimately paid back to the CRS Fund by members of that class from their pension benefits over time in a fair manner consistent with the terms of the Class Notice. The Defendants and the Current Employees Plaintiffs acknowledge and agree that Current Employees Class Counsel fees shall be based upon the value of the pension and healthcare benefits conferred upon the Current Employees Class as determined by the Court. The Defendants and Current Employees Class Plaintiffs stipulate that said benefit is at least \$40 million. The Retirees Class Representatives do not stipulate to any aspect of this proposed fee arrangement.

35. RE-OPENERS: The events or circumstances described below, upon presentation of adequate evidence to satisfy the Court that such conditions exist, shall constitute sufficient reason to re-open the Consent Decree based upon the continuing jurisdiction of the Court as set forth in Paragraph 42. The Parties acknowledge that contributions, costs, expenses, and benefits (except pension) are subject to modification to resolve a reopener.

Reopeners shall only be pursued as a last resort and must specifically meet the criteria stated for the reopener.

The Parties recognize that the pension typically provides life's basic needs for a retiree including food, clothing, shelter, and healthcare are critical to providing for their long-term financial and physical well-being. The Parties further acknowledge that, owing to age and often ill-health, the opportunity for retirees to improve their revenue stream is typically very limited. As a result, the Parties agree that no further reductions to the monthly pension annuities, including COLA, of those already retired at the time the reopener is sought will be a part of any re-opener during the Consent Decree.

The continued provision of Retirees Class Healthcare Benefits is considered a material part of the Settlement and Consent Decree. Reductions in benefits or increases in cost for Retirees Class Healthcare Benefits shall occur only with the express approval of the Court and be shared as equitably as possible among all Parties, taking into account the necessity for any solution sought, the impact on the well-being and affordability to retirees and current employees, the impact of retiree and current employee benefit reductions since 2007, the disparity, if any, in healthcare benefits being provided to retirees and current employees, and the negotiation of tradeoffs in organized labor contracts, and the availability of alternative vehicles providing substantially similar benefits.

Recognizing that it is very likely that the methods, organization, regulation, and institutional systems for delivering healthcare benefits to retirees will change during the life of the Consent Decree, the Parties agree that the process for changing the methods, organization, and/or institutional systems for delivering healthcare benefits to retirees should be something other than an adversarial reopening of the Consent Decree. If the federal or state government, or the organizational entities that customarily deliver healthcare benefits (e.g. doctors, clinics, hospitals, insurance companies) require a modification to deliver healthcare services to retirees, the parties agree to amicably negotiate the transition to available methods, organizations, regulations, and institutional systems to provide the healthcare benefits as described in this Agreement.

The Party who believes that a reopener condition exists shall issue written notice to the other Parties and to the Court explaining the basis for such reopener. It shall be the burden of the Party issuing such notice to convince the Court that there has been a material change in circumstances which meet the stated criteria warranting a reopening of the Consent Decree.

When any of the following reopener conditions is triggered by the above process, the Parties shall negotiate in good faith, subject to the Court's oversight, management, and administration, to reach an amicable resolution regarding any necessary modifications to CRS, the funds managed by the CRS, operations, benefit levels, contributions, funding sources or any other related issue consistent with this Agreement and Consent Decree. Should the Parties be unable to reach an amicable resolution regarding any necessary modification, then the Party who gave notice of the reopener must file a motion with the Court setting forth in detail the nature and/or grounds of the request for reopener and the requested modification to the CRS, the funds managed by the CRS, operations, benefit levels, contributions, funding sources or any other related issue which is sought. The Party requesting the modification shall have the burden of convincing the Court that the requested modification is in the best interest of the City, the CRS, and the members of the CRS in light of and giving due consideration to the purposes, objectives and goals of this Agreement and the Consent Decree. The Court may grant a modification to this Agreement and the Consent Decree when the requested modification is both necessary and appropriate based on the clear and convincing evidence of any of the following:

- i. There is an annual change in City total tax receipts of greater than ten percent that remains at or outside that range for five consecutive fiscal years;
- ii. There is an actual reduction in Covered Payroll of ten percent or more that has occurred or will occur and which will cause the CRS Pension Trust Fund to be 90 percent funded or less by the end of the term of the Agreement;
- iii. The actuaries of the CRS will create a Schedule of Funded Ratios (Preliminary). This chart will show the Annual Target Funded Ratio (Column 1), which, if achieved throughout the term of this Agreement, would result in the CRS Pension

Fund being fully funded at its expiration. It will be incorporated into this Agreement by reference. The Annual Minimum Funded Ratio (Column 2) will be equal to 90 percent of each year's Annual Target Funded Ratio. The Maximum Funded Ratio (Column 3) will be equal to 110 percent of each year's Annual Target Funded Ratio. If the Funded Ratio remains below the yearly Annual Minimum Funded Ratio or above the Maximum Funded Ratio for five consecutive years, any party may seek to reopen the Consent Decree. However, if the five-year annualized actual CRS return for that stated period has not exceeded the blended five year annualized actual return for that period of 75 percent of the S&P 500 Index and 25 percent of the Barclay (formerly Lehman) US Bond Index, no request for an Annual Minimum Funded Ratio reopener shall be made. The Parties further agree that the above-referenced Schedule of Funded Ratios will be revised every five years to more accurately reflect the assets and liabilities of the CRS;

- iv. The City proposes a plan to transition healthcare benefits to a Medicare exchange portal/HRA model effective no earlier than ten years after the Effective Date, so long as the model does not negatively affect healthcare benefits;
- v. CRS becomes subject to the so-called "Cadillac Tax" (as defined by the Affordable Care Act) for Retirees Class Healthcare Benefits. The City agrees to make all reasonable efforts to avoid the implementation of said tax. If the CRS becomes subject to a tax greater than ten percent of the annual cost of healthcare to the CRS for the previous fiscal year, any Party may move to reopen this Agreement;

- vi. The City proposes a plan to merge CRS functions with another public pension plan on terms that would require the assuming plan to honor all pension and other benefit commitments and costs provided for in this Agreement and the Consent Decree. The City may not propose a plan to merge for ten years following the Effective Date;
- vii. The average CPI-U Index for the most recently completed calendar year and for the previous four consecutive calendar years exceeds five percent;
- viii. If a restructuring or modification of funding healthcare through government regulation or legislation results in the 115 Trust Fund being no longer required to fund healthcare benefits for retirees, the Consent Decree may be reopened as to the use of the 115 Trust Fund;
- ix. If any cause or condition exists or comes to exist which would reduce the 30-year projected funding ratio for either the CRS Pension Trust Fund or the Section 115 Trust Fund to 90 percent or less; or
- x. If otherwise agreed upon by all the Parties.

36. Denial of Liability: Defendants dispute Plaintiffs' claims, deny that the Classes are entitled to any relief, and have asserted numerous defenses to the allegations at issue in the Actions, and would continue to do so in the event these Actions did not settle. Defendants have agreed to enter into this Settlement Agreement and the related Consent Decree without any express or implied acknowledgment, in any way, of any fault or liability to anyone, including the Plaintiffs herein. Defendants have concluded that settlement, on the terms set forth in this Agreement and the related Consent Decree, is in their best interests, taking into account, among other concerns, the inconvenience, distraction, delay, and expense associated with and the

unpredictable nature of further litigation and in an attempt to quell all controversy and to avoid additional and costly expenses, including but not limited to disruption of its business and also the burdensome, disruptive and costly litigation necessary to defend these Actions. Throughout the course of these Actions, and otherwise at all times, Defendants have denied all allegations of wrongdoing or liability whatsoever asserted and/or which could have been asserted in these Actions. Defendants continue to do so and neither this Settlement Agreement nor the related Consent Decree, nor anything contained herein, or offered and exchanged between the Parties as negotiated and/or leading to this Settlement Agreement and the related Consent Decree, may be used or construed by any person or entity as an admission or concession by Defendants of the truth of any of the allegations in the Actions, or of any liability, fault, or wrongdoing of any kind on the part of any Defendant. Other than the procedures adopted by the Consent Decree, this Settlement Agreement and related Consent Decree shall not be offered or received in evidence in any action or proceeding in any court, administrative panel or proceeding, or other tribunal, as an admission or concession of liability or wrongdoing of any nature on the part of any Defendant. In the event the Settlement Agreement and related Consent Decree are not finally approved for any reason, Defendants retain the right to contest the Actions and/or any other case on any ground.

37. Settlement Administrator and Administration: The Parties agree that the City will propose for Court approval that Class Action Administration, Inc. be designated as the Settlement Administrator. The Settlement Administrator shall (i) oversee the provision of Notice to the Current Employees Class and the Retirees Class; (ii) oversee and maintain the settlement website; (iii) audit and confirm the issuance of payments made to any Current Employees Class member pursuant to this Agreement; and (iv) provide a certification to the

Court regarding the issuance of Notice as set forth herein. Defendants shall pay the reasonable costs of administering the Settlement once Preliminary Approval is granted by the Court from general revenue funds. Such costs will include, for example, the reasonable costs of notifying the Current Employees Class members and the Retirees Class members, mailing the Class Notice, creating and maintaining a settlement website, and creating and maintaining an automated toll-free telephone number to answer frequently asked questions. The City agrees to supply to the Settlement Administrator names and last known addresses for each Current Employees Class member and each Retirees Class member. The City shall provide such information on a timely and responsive basis and in a readily usable format so as to enable the Settlement Administrator to satisfy the requirements of the Notice Program described below. For any Current Employees Class member or Retirees Class member for whom a current address cannot be located, the City shall provide the Settlement Administrator with the last known address for the representative or agent of each such Current Employees Class member and Retirees Class member.

38. Notice to Class Members: The Notice Program will consist of the following: (i) mailing of the Notice (the text of which shall substantially conform to Exhibit 2 hereto) to Current Employees Class members and Retirees Class members by first-class mail; (ii) creating and maintaining the Settlement Website (the text of which shall substantially conform to Exhibit 2 hereto) which will include a copy of the Notice, the Settlement Agreement, Consent Decree and other information relating to the terms of the Settlement; and (iii) establishing a toll free number containing answers to frequently asked questions (the text of which shall substantially conform to Exhibit 2 hereto). No later than 30 days after the Preliminary Approval Date, the Settlement Administrator shall mail the Notice by first-class mail to each Current Employees Class member and each Retirees Class member. The first day on which the Notices are mailed

shall constitute the Notice Date. The Settlement Administrator shall certify to the Court the Notice Date in writing. As necessary, the Settlement Administrator shall locate or update all addresses for Current Employees Class members and Retirees Class members prior to mailing the Notices. If any Notices are returned as undeliverable, then the Settlement Administrator shall, to the extent it is reasonably able to locate a current address, re-send all such Notices by first-class mail. If the Settlement Administrator cannot reasonably locate a current address for those Notices returned as undeliverable, then the Settlement Administrator may send such Notices by first class mail to the last known address of the agent or representative of each of these Current Employees Class members and Retirees Class members, if available.

39. Objections to the Settlement: Any Class Member who wishes to object to the fairness, reasonableness or adequacy of this Settlement Agreement, the Consent Decree, or to the requested amount of attorneys' fees and expenses must, by the date specified in the Class Notice (which will be 60 days after the Notice Date) deliver to Class Counsel and Defendants' Counsel and file with the Court a statement of the objection, as well as the specific reason(s), if any, for the objection, including any legal support and any evidence the Class Member wishes to introduce in support of the objection. Any Class Member may so object either on their own or through an attorney hired at their own expense. Any Class Member who files and serves a written objection, as described in this Section, may appear at the Fairness Hearing, either in person or through personal counsel hired at that Class Member's expense, to object to the fairness, reasonableness or adequacy of this Settlement Agreement or to the requested attorneys' fees and expenses. Class Members or their attorneys intending to make an appearance at the Fairness Hearing pursuant to their objection must no later than 14 days prior to the Fairness Hearing: (1) file a notice of intention to appear with the Court; (2) deliver to Class Counsel and

Defendants' Counsel a copy of such notice of intention; and (3) identify any documents they will seek to introduce or witnesses they intend to call at the Fairness Hearing. The Parties and their respective counsel shall not solicit or encourage any objections.

Any Class Member who fails to comply with this Section shall waive and forfeit any and all rights that the Class Member may have to appear separately or object, or to take any appeal of the orders or judgments, and shall be bound by all the terms of the Settlement Agreement, the Consent Decree and by all proceedings, order, and judgments related thereto, including but not limited to the Order Granting Final Approval. The Parties and their respective counsel will not solicit Class Members to submit written objections to the Settlement or appeal from the Court's Order Granting Final Approval.

40. Preliminary Approval Order: On or before May 6, 2015, an application will be made to the Court for an order that will, among other things:

- i. Preliminarily approve this Settlement Agreement and related Consent Decree as fair, reasonable, and adequate so as to warrant sending notice to the Classes;
- ii. Conditionally certify the Current Employees Class and the Retirees Class pursuant to Fed. R. Civ. P. 23(b)(1) and (b)(2) and appoint Current Employees Class Counsel and Retirees Class Counsel to represent the respective classes;
- iii. Approve the notice methodology described herein and the proposed Class Notice for mailing;
- iv. Direct the Settlement Administrator to mail or to cause the appropriate Class Notice to be mailed to each Class Member's last known address within 30 days from entry of the Preliminary Approval Order;

- v. Direct the Settlement Administrator to create and maintain the Settlement Website and to establish a toll-free telephone number to answer frequently asked questions within 30 days from entry of the Preliminary Approval Order;
- vi. Find that the Class Notice to be provided to Class Members: (a) is the best practicable notice; (b) is reasonably calculated to apprise Class Members of the terms of this Settlement and their right to object to the proposed Settlement; (c) is reasonable and constitutes due, adequate, and sufficient notice to all persons entitled to receive notice; and (d) meets all applicable requirements of the Federal Rules of Civil Procedure, the Class Action Fairness Act, the United States Constitution (including the Due Process Clause), the Rules of the Court, and any other applicable law;
- vii. Require each Class Member who wishes to object to submit a valid and timely statement of objection pursuant to the terms of this Agreement;
- viii. Require any attorney hired by a Class Member for the purpose of objecting to the fairness, reasonableness or adequacy of this Settlement Agreement and the Consent Decree, to any terms of the Settlement Agreement or Consent Decree, or to the proposed attorneys' fees and expenses, to file with the Court and deliver to Class Counsel and Defense Counsel a notice of appearance no later than 14 days prior to the Fairness Hearing;
- ix. Require any Class Member who files and serves a written objection and who intends to make an appearance at the Fairness Hearing, either in person or through counsel hired at that Class Member's expense, to deliver to Class Counsel and Defense Counsel and file with the Court no later than 14 days prior

to the Fairness Hearing, a notice of intention to appear and a statement identifying any documents the Class Member will seek to introduce or witnesses the Class Member will seek to call at the Fairness Hearing;

- x. Preliminarily enjoin Class Members from filing, commencing, prosecuting, intervening in, or participating (as Class Members or otherwise) in any lawsuit in any jurisdiction based on the claims in the Actions;
- xi. Schedule the Fairness Hearing no later than 120 days after the Notice Date;
- xii. Stay any and all litigation activities except for activities related to the approval and implementation of this Settlement;
- xiii. Direct Class Counsel to file their requests for attorneys' fees and expense reimbursements no later than 21 days prior to the deadline for Class Members to file any objections to this Settlement; and
- xiv. Contain any additional provisions that might be necessary to implement and administer the terms of this Settlement Agreement and the related Consent Decree.

The proposed Preliminary Approval Order is attached hereto as Exhibit 6.

41. Dismissal of *State ex rel. Council 8 AFSCME, et al. v. City of Cincinnati*: Within ten business days of Finality, the parties to *State ex rel. Council 8 AFSCME, et al. v. City of Cincinnati, et al.*, Case No. A 1 104791, pending before the Hamilton County Court of Common Pleas will stipulate to a dismissal of that action.

42. Continuing Jurisdiction Over *Sunyak and Harmon v. City of Cincinnati*: The Parties agree that the Court shall retain exclusive jurisdiction to oversee, enforce, interpret, implement, and administer this Settlement Agreement and the Consent Decree through the

pending consolidated actions, *Sunyak v. City of Cincinnati*, Case No. 1:11-cv-445 (S.D. Ohio) and *Harmon v. City of Cincinnati*, Case No. 1:12-cv-329 (S.D. Ohio). Each of the Parties expressly and irrevocably submits to the jurisdiction of the Court in connection with any proceedings related to the oversight, enforcement, interpretation, implementation, or administration of this Settlement Agreement or the Consent Decree.

43. Order Granting Final Approval of Settlement: After the conclusion of the Fairness Hearing, and upon the Court's approval of this Settlement Agreement and related Consent Decree, the Parties shall seek and obtain from the Court an Order Granting Final Approval, which shall, among other things:

- i. Find that the Court has personal jurisdiction over the Parties, and the Court has subject matter jurisdiction to approve the Settlement Agreement, including all Exhibits to the Settlement Agreement;
- ii. Approve this Settlement as fair, reasonable, and adequate, consistent and in compliance with all applicable requirements of the Federal Rules of Civil Procedure, the Class Action Fairness Act, the United States Constitution (including the Due Process Clause), the Rules of the Court, and any other applicable law, and in the best interests of each of the Parties and the Class Members;
- iii. Certify the Current Employees Class and the Retirees Class pursuant to Federal Rule of Civil Procedure 23(b)(1) and (b)(2) and finally approve and appoint Current Employees Class Counsel and Retirees Class Counsel to represent their respective class.

- iv. Direct the Parties and their counsel to implement and consummate this Settlement Agreement according to its terms and provisions;
- v. Declare this Settlement Agreement and related Consent Decree to be incorporated into the Order Granting Final Approval and to be binding on all Class Members and preclusive in all pending and future lawsuits or other proceedings;
- vi. Find that the Class Notice and the notice methodology implemented pursuant to this Settlement Agreement:
 - 1. Constituted the best practicable notice;
 - 2. Constituted notice that was reasonably calculated, under the circumstances, to apprise Class Members of the terms of the Proposed Settlement, their right to object or exclude themselves from the proposed Settlement, and their right to appear at the Fairness Hearing;
 - 3. Were reasonable and constitute due, adequate, and sufficient notice to all persons entitled to receive notice; and
 - 4. Met all applicable requirements of the Federal Rules of Civil Procedure, the Class Action Fairness Act, the United States Constitution (including the Due Process Clause), the Rules of the Court, and any other applicable law;
- vii. Find that Class Counsel and the Class Representatives adequately represented the Classes and Sub-Classes for purposes of entering into and implementing the Settlement and that Class Counsel is entitled to the payment of attorneys' fees in the amounts approved by the Court;

- viii. Order that AFSCME take all necessary actions to dismiss with prejudice *State ex rel. Council 8 AFSCME, et al. v. City of Cincinnati, et al.*, Case No. A 1 104791, within 10 days of Finality, without fees or costs to any Party except as provided in this Settlement Agreement; and
- ix. Without affecting the Finality of the Order Granting Final Approval for purposes of appeal, retain jurisdiction as to all matters relating to the administration, consummation, enforcement, and interpretation of this Settlement Agreement, the Order Granting Final Approval, the Consent Decree, and for any other necessary purpose.

The proposed Order Granting Final Approval is attached hereto as Exhibit 7.

44. Plaintiffs' Representations: Current Employees Plaintiffs and Retirees Plaintiffs represent and certify that: (1) they have been willing, able, and ready to perform the duties and obligations of representatives of the Classes; (2) they have read the pleadings in this Action, including the complaints, and have had the contents of such pleadings described to them; (3) they have been kept informed of the progress of the Actions and the settlement negotiations among the Parties, and they have either read this Settlement Agreement and related Consent Decree or have received a description of it from Class Counsel, and have agreed to the terms of the Settlement Agreement and related Consent Decree; (4) they have consulted with Class Counsel about the Actions, this Settlement Agreement and related Consent Decree and the obligations of a representative of the Classes; (5) they support this Settlement Agreement and the related Consent Decree and have agreed to execute this Settlement Agreement; and (6) they will remain and serve as representatives of the Classes until the Court authorizes their withdrawal as Class representatives. Should any Class representative withdraw, or if any Class representative

is found to be no longer capable of performing any responsibilities as a Class representative, the remaining Class representatives shall nominate replacement representatives subject to Court approval.

45. Enforcement: This Agreement is to be final and binding on all Parties and enforceable by the Court. Neither the City, City Council, nor the Board shall have any authority to take any action which is contrary to this Agreement, or which would undermine, obviate or otherwise avoid any of the material provisions contained herein. Should the City fail to take any action or make any payment required under this Agreement, the City waives any and all defenses, including, without limitation, jurisdictional defenses, and the Court's judgment shall be immediately enforceable through all means available under applicable law.

46. Governing Law: This Agreement and the Consent Decree shall be governed by and interpreted according to Ohio law.

47. Continuing Jurisdiction: The Parties agree and stipulate to the continuing jurisdiction and venue of the Court. Any action to enforce this Settlement Agreement or the related Consent Decree (including enforcing any re-opener provision) shall be commenced and maintained only in the Court. The administration, execution, interpretation, consummation, and enforcement of the Settlement Agreement and the related Consent Decree shall be under the authority of the Court. AFSCME shall have standing to enforce this Agreement and to assert any reopener.

48. No Presumption Against Drafter: The Parties agree that this Settlement Agreement and the related Consent Decree was drafted by counsel for the Parties at arm's length, with substantial input from all Parties and their counsel, and no reliance was placed on any representations other than those contained herein. The Parties agree that the Settlement

Agreement and the Consent Decree shall be construed by its own terms, and not by any presumption against the drafter; and that no parol or other evidence may be offered to explain, construe, contradict, or clarify its terms, the intent of the Parties or their counsel, or the circumstances under which the Settlement Agreement and related Consent Decree were drafted or executed.

49. No Tax Opinions: No opinion concerning the tax consequences of the proposed Settlement to individual Class Members is being given or will be given by Plaintiffs, Class Counsel, Defendants, or Defendants' counsel; nor is any representation or warranty in this regard made by virtue of this Settlement Agreement or the Consent Decree.

50. Counterparts Permitted: This Agreement and related Consent Decree may be signed in counterparts, each of which shall constitute a duplicate original. Electronic or facsimile transmitted copies of the signatures shall constitute a duplicate original.

51. Successors and Assigns: The provisions of this Agreement, the related Consent Decree, and all Exhibits and documents relating thereto shall be binding upon and inure to the benefit of the respective successors and assigns of the Plaintiffs, members of the Classes, Class Counsel, and Defendants.

52. General Compliance Reviews: In order to monitor and report on the implementation of this Agreement and Consent Decree, the City and Class Counsel shall regularly conduct compliance reviews to ensure that Defendants have implemented and continue to implement all measures required by this Agreement. Each Party shall designate counsel to serve as liaisons to the Court for compliance purposes. This counsel shall serve as a liaison between the City and the Court, and shall assist with the City's compliance with this Agreement. The City will provide access to such public documents as are required to properly ensure

compliance with the terms set forth in this Agreement. Liaison counsel will be permitted to apply for an award of fees for any services rendered to be paid by the City. The City shall be liable for payment of liaison counsel fees up to \$5,000 in any given year.

53. Regular Status Reports: Beginning six months after the Effective Date, and every 12 months thereafter until this Agreement is terminated, the City and Class Counsel shall file a status report with the Court, including any supporting documentation, delineating all steps taken during the reporting period to comply with this Agreement. These reports shall track the Defendants' attainment of the requirements and goals contained in this Agreement, identify any areas of alleged non-compliance, instruct the Court as to how the Parties intend to remedy any areas of alleged non-compliance and, if necessary, request that the Court issue orders on compliance as necessary. If the Court issues any such order to ensure compliance with this Agreement and the related Consent Decree, the Party or Parties subject to the Order shall have 60 days from receipt of such Order to cure the asserted failure. On or before the termination of this 60 day period, the Party or Parties subject to the Order shall file an additional report with the Court documenting efforts taken to comply with the Court's Order. The Court may award reasonable attorneys' fees incurred by any party to secure compliance with this Agreement and require the responsible Party or Parties to this Agreement to pay the same.

54. Record Keeping Requirements: During the term of this Agreement and the Consent Decree, and subject to record retention requirements and procedures imposed by federal, state or local law, or any relevant collective bargaining agreement, the City and Class Counsel shall maintain all records documenting compliance with this Agreement and all documents required by or developed pursuant to this Agreement. These records shall be made

available to all Parties upon request in accordance with all state and federal laws requiring open records provisions.

55. Arms-Length Negotiations: This Agreement is the product of extensive arms-length negotiations by competent legal counsel for the Parties.

56. No Admission of Liability: The Parties agree that they are entering into this Agreement for settlement purposes only. Any acquiescence or agreement to the class certification in this case does not constitute an admission of liability or fault by the City and may not be used as evidence in any proceeding for damages by any member of the Classes.

57. No Retaliation: No Party shall retaliate in any manner against any other Party, including any members of the Classes, for their participation in the Actions or this Settlement.

58. Obligation to Cooperate and Use Best Efforts: All Parties hereto agree to exercise their best efforts and to take all reasonable steps necessary to effectuate the Settlement set forth in this Agreement.

59. Entire Agreement: This Agreement and the related Consent Decree constitute the entire agreement and accord among the Parties with regard to the subject matter of this Agreement.

60. Notice: Any notice, request, instruction, Order, or other document to be given hereunder by any Party hereto to any other Party (other than class notification) shall be in writing and delivered personally or sent registered or certified mail, postage prepaid, to the Parties as follows:

To: City of Cincinnati

City Manager Harry Black or his successor as Chief Executive Officer of the City of Cincinnati
with a copy to City Solicitor Paula Boggs Muething or her successor as Chief Legal Officer of the City of Cincinnati

City Hall
801 Plum Street
Cincinnati, OH 45202

Steven P. Goodin
John B. Pinney
Graydon Head & Ritchey LLP
1900 Fifth Third Center
511 Walnut Street
Cincinnati, OH 45202

To: Current Employee Class Counsel

Christian A. Jenkins
Minnillo & Jenkins Co., LPA
2712 Observatory Ave.
Cincinnati, OH 45202

Marc Mezibov
401 E. Court Street, Suite 600
Cincinnati, OH 45202

Robert D. Klausner
Klausner Kaufman Jensen & Levinson
7080 Northwest Fourth Street
Plantation, FL 33317

Jeffrey S. Goldenberg
Goldenberg Schneider, LPA
One West Fourth Street, 18th Floor
Cincinnati, OH 45202

To: Retiree Class Counsel

Robert A. Pitcairn, Jr.
James F. McCarthy, III
Peter J. O'Shea
Katz Teller
255 East Fifth Street, 24th Floor
Cincinnati, OH 45202-4724

To: AFSCME Council No. 8

R. Sean Grayson
6800 N. High Street
Worthington, Ohio 43085-2512

61. Public Document: This Agreement is a public document and shall be posted on appropriate websites maintained by the City and the CRS.

62. Modification: This Agreement may only be modified in writing and with consent of the Parties, subject to the approval of the Court or by order of the Court.

63. Termination: This Agreement will terminate 30 years after the Effective Date.

64. Implementation Date: Any provision of this Agreement which is silent as to the implementation date shall be implemented on the Effective Date or January 1, 2016, whichever is later.

The below Parties have read and agree to the terms of this Collaborative Settlement Agreement and related Consent Decree:

Retirees Plaintiffs and Putative Retirees Class Representatives

/s/ Thomas A. Gamel, Sr May 7, 2015
Thomas A. Gamel, Sr., Date

/s/ Paul Smith May 7, 2015
Paul Smith Date

/s/ Mark K. Jones May 7, 2015
Mark K. Jones Date

/s/ Dennis Davis May 7, 2015
Dennis Davis Date

/s/ Ely Ryder May 7, 2015
Ely Ryder Date

/s/ Ann DeGroot May 7, 2015
Ann DeGroot Date

The below Parties have read and agree to the terms of this Collaborative Settlement Agreement and related Consent Decree:

Defendants:

/s/ John Cranley
Honorable John Cranley
Mayor of City of Cincinnati

April 29, 2015
Date

/s/ Harry Black
Harry Black
City Manager of Cincinnati, on behalf of City Defendants

April 29, 2015
Date

/s/ Paula Boggs Muething
Paula Boggs Muething
On behalf of City Defendants

April 29, 2015
Date

The below Counsel have read and agree to the terms of this Collaborative Settlement Agreement and related Consent Decree:

Current Employees Class Counsel:

/s/ Jeffrey S. Goldenberg May 7, 2015
Jeffrey S. Goldenberg Date

/s/ Christian A. Jenkins May 7, 2015
Christian A. Jenkins Date

/s/ Robert D. Klausner May 7, 2015
Robert D. Klausner Date

/s/ March Mezibov May 7, 2015
Marc Mezibov Date

Retiree Class Counsel:

/s/ Robert A. Pitcairn, Jr. May 7, 2015
Robert A. Pitcairn, Jr. Date

/s/ James F. McCarthy, III May 7, 2015
James F. McCarthy, III Date

AFSCME Council No. 8:

/s/ R. Sean Grayson May 7, 2015
R. Sean Grayson Date

Counsel for City of Cincinnati:

/s/ Steven P. Goodin May 7, 2015
Steven P. Goodin Date

EXHIBIT ONE

PROPOSED

CONSENT

DECREE

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION**

SUNYAK, et al.,	:	Case Nos. 1:11-cv-445
	:	1:12-cv-329
v.	:	
	:	Judge Michael R. Barrett
CITY OF CINCINNATI, et al.,	:	
	:	
(City of Cincinnati Pension Litigation)	:	

PROPOSED CONSENT DECREE

Pursuant to the Court’s authorization and approval as demonstrated by its signature below, the City of Cincinnati (“City”), the Cincinnati Retirement System (“CRS”), John Cranley (“Mayor”), and City Manager Harry Black (“City Manager”), the Vice Mayor, the Members of City Council , and the Board of Trustees of the CRS (collectively, the “Defendants”), and Nick Sunyak, Jeffery Harmon, Jill Algeyer, Kim Kappel, Waleia Jackson, Finley Jones, and Richard Ganulin, on behalf of themselves and the Current Employees Class they represent, and Thomas A. Gamel, Sr., Paul Smith, Mark K. Jones, Dennis Davis, Ely Ryder, and Ann DeGroot, on behalf of themselves and the Retirees Class they represent, and the American Federation of State and Municipal Employees Ohio council No. (“AFSCME”), collectively “the Parties,” consistent with and in furtherance of implementing the Collaborative Settlement Agreement (“Settlement Agreement” or “Settlement”) approved by the Court on _____, 2015 (Doc. No. _____) which completely resolves and settles the City of Cincinnati Pension Litigation, do hereby agree, stipulate and consent to following:

1. This Consent Decree adopts and incorporates by reference in its entirety the Settlement Agreement, including all defined terms therein.

2. This Consent Decree establishes that the Court shall retain exclusive jurisdiction to oversee, enforce, interpret, implement, and administer the Settlement Agreement and this Consent Decree through the pending consolidated actions, *Sunyak v. City of Cincinnati*, Case No. 1:11-cv-445 (S.D. Ohio) and *Harmon v. City of Cincinnati*, Case No. 1:12-cv-329 (S.D. Ohio).

3. This Consent Decree establishes that each of the Parties expressly and irrevocably submits to the jurisdiction of the Court in connection with any proceedings related to the oversight, enforcement, interpretation, implementation, or administration of the Settlement Agreement or this Consent Decree until Termination.

4. This Consent Decree establishes that AFSCME shall have standing to enforce the terms of the Settlement Agreement and this Consent Decree.

5. The Parties shall, at all times prior to Termination, work together in good faith to effectively and efficiently implement all the terms of the Settlement and this Consent Decree. Further, each Party recognizes that they have an obligation to cooperate and use their best efforts in this regard and to take all reasonable steps necessary to effectuate the terms of the Settlement. These terms include, but are not limited to:

- a. The creation of the CRS Pension Trust Fund and the 115 Trust Fund
(Collaborative Settlement Agreement, at p. 21)
- b. Transfer funds to the 115 Trust Fund (Id. at p. 22)
- c. CRS COLA Calculation (Id. at p. 22)
- d. Current Employees Class COLA Delay Period (Id. at p.23)
- e. Retirees Class COLA Suspension Period (Id. at 24)
- f. COLA Poverty Exception (Id.)

- g. Current Employees Class Retirement Eligibility (Id. at p. 25)
- h. Retirement Benefit Multiplier Calculation (Id.)
- i. Final Average Salary Calculation (Id.)
- j. Early Retirement Eligibility (Id. at p. 26)
- k. Annuity Adjustments (Id.)
- l. Employee Contributions (Id. at p. 27)
- m. The Group C Settlement Payments (Id.)
- n. The City's Annual Contribution to the CRS Pension Trust Fund (Id. at p. 28)
- o. Additional contributions to the CRS Pension Trust Fund (Id.)
- p. Deferred Retirement Option Plan ("DROP") (Id. at p. 29)
- q. Retirees Class Healthcare Benefits (Id. at p. 30)
- r. Current Employees Class Retirement Healthcare Benefits (Id.)
- s. Current Employees Class Retirement Healthcare Premium Percentages (Id.)
- t. Healthcare Modifications for Retirees (Id. at p. 32)
- u. Healthcare Funding Obligation (Id.)
- v. Retirees Class Death Benefit (Id.)
- w. Assumed Rate of Return (Id.)
- x. Pension Board Reforms (Id. at p. 33)
- y. Disgorgement provision (Id. at p. 35)
- z. Actuarial Confirmation provision (Id. at p. 36)
- aa. Reopeners provision (Id. at p. 37)
- bb. Enforcement Reporting (Id. at p. 50)
- cc. Compliance Reviews (Id. at p. 52)

dd. Recordkeeping (Id. at p. 53)

6. This Consent Decree shall be governed by and interpreted according to Ohio law.

7. Any action to enforce this Consent Decree (including enforcing any re-opener provision) shall be commenced and maintained only in the United States District Court for the Southern District of Ohio.

8. This Consent Decree may be signed in counterparts, each of which shall constitute a duplicate original. Electronic or facsimile transmitted copies of the signatures shall constitute a duplicate original.

9. The provisions of this Consent Decree, and all exhibits and documents relating thereto shall be binding upon and inure to the benefit of the respective successors and assigns of the Plaintiffs, members of the Classes, Class Counsel, and Defendants.

10. Additional Current Employees Class Representatives, additional Current Retirees Class Representatives, or additional counsel for any of the Parties may be approved by the Court as necessary due to health, availability, or other concerns or issues that may arise prior to Termination.

11. To assist the Court in monitoring the Parties' implementation of the Settlement Agreement, the Parties shall regularly conduct Compliance Reviews to ensure that they have implemented and continue to implement all measures required by this Agreement. Each Party shall designate counsel to serve as liaisons to the Court for compliance purposes. This counsel shall serve as a liaison between the City and the Court, and shall assist with the City's compliance with this Agreement. The City will provide access to such documents, records and other information reasonably needed to ensure compliance with the terms set forth in the Settlement Agreement and this Consent Decree.

12. Beginning six (6) months after the Effective Date, and every six (6) months thereafter until Termination (unless a different time period is ordered by the Court), the Parties shall file a joint status report with the Court, including any supporting documentation, delineating all steps taken during the reporting period to comply with the terms of the Settlement Agreement. These reports shall track the Parties' attainment of the requirements and goals contained in the Settlement Agreement, identify any areas of alleged non-compliance, instruct the Court as to how the Parties intend to remedy any areas of alleged non-compliance and, if necessary, request that the Court issue orders on compliance. If the Court issues any such order to ensure compliance with this Agreement and the related Consent Decree, the Party or Parties subject to the Order shall have 60 days from receipt of such Order to cure the asserted failure. On or before the termination of this 60 day period, the Party or Parties subject to the Order shall file an additional report with the Court documenting efforts taken to comply with the Court's Order.

13. For all periods of time until Termination of the Settlement Agreement, and subject to record retention requirements and procedures imposed by federal, state or local law, or any relevant collective bargaining agreement, the Parties shall maintain all records documenting compliance with the Settlement Agreement and all documents required by or developed pursuant to the Settlement Agreement.

14. No Party shall retaliate in any manner against any other Party, including any member of the Classes, for their participation in the this Settlement or for their participation in any actions related to the enforcement or reporting or recordkeeping provisions of this Settlement and this Consent Decree.

15. Any notice, request, instruction, Order, or other document to be given hereunder by any Party hereto to any other Party (other than class notification) shall be in writing and delivered personally or sent registered or certified mail, postage prepaid, to the Parties as follows:

To: City of Cincinnati

City Manager Harry Black
with a copy to City Solicitor Paula Boggs Muething
City Hall
801 Plum Street
Cincinnati, OH 45202

Steven P. Goodin
John B. Pinney
Graydon Head & Ritchey LLP
1900 Fifth Third Center
511 Walnut Street
Cincinnati, OH 45202

To: Current Employees Class Counsel

Christian A. Jenkins
Minnillo & Jenkins Co., LPA
2712 Observatory Ave.
Cincinnati, OH 45202

Marc D. Mezibov
401 E. Court Street, Suite 600
Cincinnati, OH 45202

Robert D. Klausner
Klausner Kaufman Jensen & Levinson
10059 Northwest 1st Court
Plantation, FL 33324

Jeffrey S. Goldenberg
Goldenberg Schneider, LPA
One West Fourth Street, 18th Floor
Cincinnati, OH 45202

To: Retirees Class Counsel

Robert A. Pitcairn, Jr.
James F. McCarthy, III
Katz Teller Brant & Hild
255 East Fifth Street, 24th Floor
Cincinnati, OH 45202-4724

To: AFSCME Council No. 8

R. Sean Grayson
6800 N. High Street
Worthington, Ohio 43085-2512

16. This Consent Decree is a public document and shall be posted on appropriate websites maintained by the City and the CRS.

17. Unless otherwise provided herein, this Consent Decree may only be modified in writing and with consent of the Parties, subject to the approval of the Court.

18. This Consent Decree will terminate 30 years after the Effective Date.

The below Parties have read and agree to the terms of this Consent Decree:

Current Employees Plaintiffs and Putative Class Representatives

Nick Sunyak

Date

Jeffrey Harmon

Date

Jill Allgeyer

Date

Kim Kappel

Date

Waleia Jackson

Date

Richard Ganulin

Date

Finley Jones

Date

The below Parties have read and agree to the terms of this Consent Decree:

Retirees Plaintiffs and Putative Class Representatives

Thomas A. Gamel, Sr.,

Date

Donald C. Beets

Date

Paul Smith

Date

Mark K. Jones

Date

Dennis Davis

Date

Ely Ryder

Date

Ann DeGroot

Date

The below Parties have read and agree to the terms of this Consent Decree and have been duly authorized and empowered to execute the Settlement Agreement and this Consent Decree as binding and lawful obligations of the Defendants:

Defendants

Honorable John Cranley
Mayor of City of Cincinnati

Date

Harry Black
City Manager of Cincinnati, on behalf of City Defendants

Date

Paula Boggs Muething
City Solicitor of Cincinnati

Date

As indicated below by their signatures, Counsel for the Parties affirm that they have read this Consent Decree, have conferred with their respective clients about the same who support this Consent Decree, agree to the provisions contained herein and shall be bound hereby:

Steven P. Goodin
John B. Pinney
GRAYDON HEAD & RITCHEY LLP
1900 Fifth Third Center
511 Walnut Street
Cincinnati, OH 45202-3157
Of Counsel for the City Solicitor

Date

Marc D. Mezibov
Susan M. Butler
401 East Court Street, Suite 600
Cincinnati, OH 45202
Counsel for Current Employees Plaintiffs and Putative Current Employees Class

Date

Christian A. Jenkins
Minnillo & Jenkins, Co. LPA
2712 Observatory Ave.
Cincinnati, OH 45202
Counsel for Current Employees Plaintiffs and Putative Current Employees Class

Date

Jeffrey S. Goldenberg
Goldenberg Schneider, LPA
One West Fourth Street, 18th Floor
Cincinnati, OH 45202-2012
Counsel for Current Employees Plaintiffs and Putative Current Employees Class

Date

Robert D. Klausner
Klausner Kaufman Jensen & Levinson
7080 NW 4th Street
Plantation, FL 33317
Counsel for Current Employees Plaintiffs and Putative Current Employees Class

Date

Robert A. Pitcairn, Jr.
Katz, Teller, Brant & Hild
255 East Fifth Street, Suite 2400
Cincinnati, OH 45202
Counsel for Retirees Plaintiffs and Putative Retirees Class

Date

R. Sean Grayson
6800 North High Street
Worthington, OH 43085-2512
General Counsel for Ohio Council 8, AFSCME

Date

This Consent Decree governing the resolution of the Cincinnati Pension Litigation is authorized and approved this ___ day of _____, 2015.

Judge Michael R. Barrett

EXHIBIT TWO

PROPOSED

SETTLEMENT

NOTICE

**Notice of Proposed Class Action Settlement
Concerning the Cincinnati Retirement System**

**IMPORTANT- A FEDERAL COURT AUTHORIZED THIS NOTICE
YOUR RIGHTS WILL BE AFFECTED WHETHER YOU ACT OR DO NOT ACT
PLEASE READ THIS NOTICE CAREFULLY**

I. NOTICE OF YOUR RIGHTS

This Notice provides a summary of the proposed class action Settlement of two consolidated cases pending before the Honorable Judge Michael R. Barrett in the United States District Court for the Southern District of Ohio: (1) *Sunyak v. City of Cincinnati*, Case No. 1:11-cv-445; and (2) *Harmon v. City of Cincinnati*, Case No. 1:12-cv-329. You are covered by the proposed Settlement because the City of Cincinnati's records indicate that you are a member of either the **Current Employees Class** or the **Retirees Class**.

The **Current Employees Class** includes City of Cincinnati employees who participated in the Cincinnati Retirement System ("CRS") with at least five years of creditable service and who were actively employed or otherwise qualified for benefits on July 1, 2011 and who are members of Group C, D, E or F as defined by Cincinnati Municipal Code § 203-1-M1 (b), (c), (d), and (e). The Current Employees Class also includes City of Cincinnati employees who had at least five years of creditable service on July 1, 2011 and who retired on or after that date, as well as veterans who purchase service credit sufficient to satisfy the requirement to have five years of creditable service as of July 1, 2011.

The **Retirees Class** includes retired City of Cincinnati, University of Cincinnati, University Hospital f/k/a General Hospital and Hamilton County employees (or the Dependent and/or Surviving Beneficiaries of a former employee) who participated in the CRS and: (a) Currently receive retirement or pension benefits, including healthcare benefits; and (b) retired on or before July 1, 2011.

This Notice generally describes the proposed Settlement and your rights as a member of either the Current Employees Class or the Retirees Class. Additional information about this proposed Settlement can be found at www.CRSPensionSettlement.com. The Court will conduct a Fairness Hearing at 10 a.m. on _____, 2015 at the United States District Court for the Southern District of Ohio, 100 East 5th Street, Courtroom ---, Cincinnati, Ohio 45202.

II. BACKGROUND

The Plaintiffs are current employees of the City of Cincinnati ("City") and retirees participating in the CRS who filed federal class action lawsuits claiming that the City and others improperly changed vested retirement benefits by adopting and enforcing City Ordinance No. 84-2011 (the "Ordinance") effective July 1, 2011, and/or that the City has threatened to make additional improper changes to retirement benefits, including the suspension or reduction of retiree health

benefits and the annual Cost of Living Adjustment (“COLA”). The City and the other Defendants deny these allegations and believe their actions were proper. Following extensive litigation and negotiations, the Plaintiffs, the Current Employees Class, the Retirees Class, the City, and the CRS (the “Parties”) have entered into a Settlement Agreement. This Settlement is a compromise of disputed claims and defenses. The Court has reviewed and preliminarily approved the Settlement as fair, reasonable, and adequate and has approved the content and mailing of this Notice.

III. SUMMARY OF THE PROPOSED SETTLEMENT

The proposed Settlement provides that the CRS will be subject to a 30-year Consent Decree enforced by the Federal Court. Once the Settlement becomes effective, no changes to the CRS benefit provisions can be made during that 30-year time period without prior approval of the Court through a re-opener process. Under the proposed Settlement, current monthly pension benefits received by members of the Retirees Class cannot be reduced from their current levels. Specific provisions of the Settlement apply to the Current Employees Class and Groups C, D, E and F as defined by the Ordinance, as well as to the Retirees Class. The complete detailed Settlement Agreement and all other documents relating to the proposed Settlement can be obtained from the Settlement website at www.CRSPensionSettlement.com or by calling [insert]. The following is a summary of the basic terms of the proposed Settlement which are scheduled to be implemented on January 1, 2016 if the Court grants final approval:

Cost of Living Adjustment: Effective January 1, 2016, the COLA for all current and future retirees in the Current Employees Class and the Retirees Class will be a 3.00 percent fixed simple COLA. This means that an annual pension benefit of \$10,000 will increase to \$10,300 in the first year that the COLA applies, \$10,600 in the second year, \$10,900 in the third year, and so on.

COLA Delay or Suspension: Current Employees Class Members and Retirees Class Members are both subject to a three-year COLA delay or suspension period, to begin on the date of retirement for members of the Current Employees Class or on January 1, 2016 for the Retirees Class. Members of the Retirees Class shall receive a one-time payment calculated at three percent of their base pension annuity benefit (but in any event, capped at \$1,000) at the commencement of the third year of their respective COLA suspension period. This one time payment will not be added to the base benefit or affect the amount of future benefits.

Retirement Eligibility: Current Employees Class Members can retire with full benefits upon reaching 30 years of service without regard to age, or at age 60 with five years of creditable service.

Retirement Benefit Multiplier Calculation: Current Employees Class Members’ retirement benefits will be computed with a 2.5 percent multiplier for the greater of 20 years of service or the number of years of service prior to July 1, 2011 for members of Group F and the number of years prior to January 1, 2014 for members of Group E. A multiplier of 2.2 percent will apply to all other years, including years of service in excess of 30 years. Final average salary calculation will continue as provided in the Ordinance.

Early Retirement Options: For Current Employees Class members, the early retirement options for individuals age 55 with 25 years of service and age 60 with at least five years of service that existed prior to the Ordinance will be reinstated.

Group D, E, and F Pension Annuity Adjustments: Current Employees Class members in Groups D, E and F who retired (or will retire) prior to January 1, 2016 will have their pension benefits increased on January 1, 2016 to reflect the provisions of this Settlement, and such individuals will receive a lump sum payment reflecting any amounts they would have received from their date of retirement until January 1, 2016 had the Settlement been in effect when they retired.

Current Employees Class Contributions: Pension contributions made by Current Employees Class Members shall not exceed nine percent of pensionable wages during the term of the Consent Decree.

Group C Settlement Payment: Current Employees Class members in Group C will receive a one-time payment between \$125 and \$625, depending on their date of retirement, as compensation for the compounding COLA they would have received, if any, during the period prior to January 1, 2016. In addition, members of Group C will be entitled to the same rights with respect to retiree health care as members of the Retirees Class, including continued eligibility for retiree health benefits for those who retire with at least 15 years of creditable service.

City's Annual Contribution Rate: The City will contribute 16.25 percent of its payroll to the CRS annually during the 30-year duration of the Consent Decree.

Voluntary Deferred Retirement Option Plan: A voluntary Deferred Retirement Option Plan ("DROP") will be implemented for Current Employees Class members which will allow them to cease accruing service credit in, and contributing to, the CRS when they obtain 30 years of service while continuing their City employment for up to five years. DROP participants will accrue their monthly retirement benefits on a pre-tax basis for up to five years of continued City employment, during which time such amounts may experience earnings but not losses. The DROP will be evaluated within five years after the Settlement goes into effect to ensure that it is cost neutral to the CRS.

Retirees Class Healthcare: Members of the Retirees Class will continue to receive healthcare benefits according to the plan in effect on December 31, 2014, as specifically provided in the Settlement. In addition, the City will implement an Employee Group Waiver Plan ("EGWP") for retirees to maximize reimbursement from federal healthcare programs. The City will also implement a voluntary medical expense reimbursement program ("MERP") to reimburse CRS participants who elect to enroll in benefits packages not funded by the CRS.

Current Employees Class Healthcare: Members of the Current Employees Class who retire in the future will be eligible for retiree healthcare benefits at that time under the most favorable terms available to current employees of the City if they have 30 years of creditable service at the time of their retirement or are at least 60 years old and have at least 20 years of service at the

time of their retirement. The cost of these healthcare benefits will be limited to ten percent of the applicable premium for individuals hired before January 9, 1997. Individuals hired after January 9, 1997 who qualify for retirement healthcare benefits will pay no more than the percentage of premium provided by the “point system” in the Cincinnati Municipal Code as of January 1, 2015. The Settlement also provides for a process to negotiate improvements in the “point system” for these individuals within six months after the Effective Date. However, these provisions will not apply to Subgroup C of the Current Employees Class. Subgroup C members are entitled to the same retirement healthcare as the Retirees Class on the same terms received by the Retirees Class as long as Subgroup C members retire with at least 15 years of creditable service.

Additional important terms and details are described in the complete Settlement Agreement available at www.CRSPensionSettlement.com, and answers to frequently asked questions can be obtained by calling **[[insert]]**.

IV. YOUR LEGAL RIGHTS REGARDING THIS SETTLEMENT

This Notice explains your rights under the Settlement and provides you with information intended to help you understand the terms of this Settlement and how it will affect you. **You may not exclude yourself from or opt out of this Settlement. If the Court grants final approval, you will be covered by this Settlement.** The following table provides a summary of the actions you can take under this Settlement:

YOUR LEGAL RIGHTS AND OPTIONS IN THIS SETTLEMENT

DO NOTHING	You will be included in the Settlement and covered by its terms if the Settlement is approved by the Court. You waive your right to object to the Settlement or to take any appeal of any orders of judgment including but not limited to the Order Granting Final Approval.
OBJECT	If you wish to object to the fairness, reasonableness, or adequacy of the proposed Settlement, or to the requested attorneys’ fees and expenses, you must send your written statement to the Court, Class Counsel, and Defendants’ Counsel postmarked no later than (insert date) as described below in Section V, Paragraph 10.
ATTEND FAIRNESS HEARING	The last step in the Settlement approval process is the Fairness Hearing, at which time the Court will hear all evidence and arguments necessary to conclusively evaluate whether to grant final approval to the Settlement. Attendance at the Fairness Hearing alone does

	not allow you to object to the Settlement. Only the written statement described above permits you to object.
--	--

Please note that this Notice does not contain all the terms and conditions of the Settlement. A copy of the actual Settlement Agreement is available at www.CRSPensionSettlement.com, or upon request by calling (**insert number**).

V. FREQUENTLY ASKED QUESTIONS AND ANSWERS

What is this lawsuit about?

The Plaintiffs in this lawsuit are current and former employees (or their survivors entitled to pension benefits) of the City who filed class action lawsuits alleging that Defendants improperly impaired or revoked their vested retirement benefits by adopting and enforcing a city ordinance which became effective July 1, 2011 (the “Ordinance”). The Ordinance substantially modified the future retirement benefits and eligibility rules for current employees by requiring them to contribute more of their earnings to the CRS and work more years to obtain lower retirement benefits than previously provided by the CRS. The Ordinance also modified the health benefits available to retirees by increasing deductibles, costs for prescriptions, and out-of-pocket caps for healthcare. The Retirees were also very concerned that the City would make additional changes to their retirement benefits, including the suspension or reduction of retiree health benefits and the annual COLA. The Defendants deny Plaintiffs’ allegations and believe their actions were legal and proper.

What is a class action?

In a class action, one or more people called class representatives sue on behalf of people who have similar claims. Together they are called the “Class.” Individuals in the Class are called “Class Members.” In a class action, one court resolves the issues for all Class Members.

Why is this lawsuit a class action?

The Court has preliminarily decided that this lawsuit can proceed as a class action for purposes of settlement because it meets the requirements of Federal Rule of Civil Procedure 23, which governs class actions in federal court. When, as here, the Parties propose to settle a class action, the Court must determine whether the Settlement is fair, adequate, and reasonable for all members of the Classes.

Has the Court decided who is right? Why is there a Settlement?

No, the Court has not decided whether Plaintiffs or Defendants are correct. There has been no trial or final ruling on the Plaintiffs’ claims or the Classes’ claims, nor is this Settlement an admission of any wrongdoing on the part of the City or any Defendant. Instead, the Parties determined it was in their best interests and the public interest to participate in a collaborative mediation process in which all issues relating to the CRS plan were addressed in an open,

comprehensive, and exhaustive manner. Without this collaborative exercise, the possibility that the City or one or both of the Classes may have suffered serious consequences was likely. Under Ohio law decided before this case was brought, the City was authorized to curtail or even eliminate all retiree healthcare benefits for both current and future retirees. The proposed Settlement preserves significant retiree healthcare benefits for current and future retirees. This proposed Settlement is a result of that process, and if approved by the Court, will allow all Parties to avoid the costs, delays, and uncertainties of a trial and appeals, will provide relief to Class Members as described above, and protect the CRS so that it may continue to provide benefits into the future.

Why did I get this Notice? Am I a part of this Class Action Settlement?

You are receiving this Notice because the City's records show that you are a member of either the Current Employees Class or the Retirees Class. As a Class Member, you are covered by this Settlement.

What are the terms of the proposed Settlement?

The terms have been summarized above in Section III of this Notice. More information about this Settlement is available at www.CRSPensionSettlement.com or by calling (insert number).

When will the Settlement go into effect for me?

There will be a Fairness Hearing on [insert]. The Court will then decide whether to approve the proposed Settlement. Class Counsel does not know how long it will take for the Court to make this decision.

If the Court grants final approval of the Settlement, the Settlement should go into effect on January 1, 2016.

Do I have an attorney in this case?

Yes. The Court has preliminarily approved attorneys Christian A. Jenkins, Jeffrey S. Goldenberg, Robert D. Klausner, and Marc D. Mezibov to represent the Current Employees Class and James F. McCarthy, Peter J. O'Shea, Robert A. Pitcairn, Jr., and the law firm of Katz, Teller, Brant & Hild to represent the Retirees Class. These attorneys are called Class Counsel. They are experienced in handling class actions against large entities, including municipalities.

You may, but do not need to, hire your own attorney because Class Counsel are working on your behalf. If you want your own attorney, you will have to pay for that attorney. For example, you can ask him or her to appear in Court for you if you want a lawyer to argue your objection to the Settlement or if you want someone other than Class Counsel to speak for you.

How will the attorneys for the Classes be paid?

Class Counsel will ask the Court to approve the payment of attorneys' fees and expenses related to this litigation via an attorney fee application that will be filed with the Court no later than ---- -, 2015. It will be up to the Court to determine the amount of fees and expenses to be paid to Class Counsel.

Current Employees Class Counsel's fee request will be based upon the value of the benefits conferred upon the Current Employees Class by this Settlement and will not exceed \$5,000,000. Current Employees Class Counsel estimate that the value of the benefits conferred upon the Current Employees Class by this Settlement exceed \$50,000,000.

The Current Employees Class Counsel will request that the amount of attorneys' fees and expenses awarded by the Court to Current Employees Class Counsel be paid by the CRS on behalf of the Current Employees Class members and then recouped in a fair manner from the benefits these members receive in the future over a 20-year period. Current Employees Class Counsel will ask the Court to assign a higher share of attorneys' fees to those Current Employees Class members who, as a result of this Settlement, have the opportunity to retire with full pension benefits prior to age 60. If the Court awards \$5,000,000 in attorneys' fees to Current Employees Class Counsel, it is estimated that these Current Employees Class members (those who will be able to retire with full pension benefits prior to age 60) will pay approximately \$_____ per month while the other Class members will pay approximately \$_____ per month

Retirees Class Counsel's fee request will be based upon calculating how many hours were spent on the Litigation and multiplying those hours by a judicially-determined reasonable rate. This is known as a lodestar calculation. In addition, Retirees Class counsel will request an enhancement of fees. The amount of the enhanced fees and costs requested will not exceed \$500,000. Retirees Class Counsel will request that the Court require the City to pay this sum from its General Fund. The City objects to paying any amount from its General Fund and will request that this amount come from the CRS Pension Fund.

How can I object to the Settlement?

You and/or an attorney you hire at your own expense may object to the proposed Settlement if you do not like any part of it, but you must follow these procedures for the Court to consider your objection:

(a) The objection must be in writing. A letter is sufficient. It must contain your name, your current address, specific reasons why you object to the Settlement (including any legal authorities), and a description of the evidence (documents or testimony) that you propose to introduce in support of the objection. You and/or your attorney you hire at your own expense must sign the objection.

(b) Your written objection must be filed with the Court **and** postmarked and mailed to the below addresses for Class Counsel and Defendants' Counsel no later than _____, 2015.

(c) If you have hired an attorney, that attorney must file a notice of appearance with the Court **and** postmark and mail such notice to the below addresses for Class

Counsel and Defendants' Counsel no later than _____, 2015.

The Court's address is: United States District Court for the Southern District of Ohio, 100 East 5th Street, Cincinnati, Ohio 45202.

Class Counsel's addresses are:

Current Employees Class Counsel: Marc Mezibov, The Law office of Marc Mezibov, 401 East Court Street, Suite 600, Cincinnati, Ohio 45202

Retirees Class Counsel: James F. McCarthy, Katz Teller Brant & Hild, 255 East Fifth Street, Suite 2400, Cincinnati, Ohio 45202

Defendants' Counsel: Steven P. Goodin, Graydon, Head & Ritchey, LLP, Fifth Third Center, 511 Walnut Street, Suite 1900, Cincinnati, Ohio 45202

If you do not follow the above procedures, including filing the objection by the date provided, you waive your right to object to the Settlement Agreement or take an appeal from any Court order, including the Order Granting Final Approval.

Do I have to come to the Fairness Hearing?

No, but you are welcome to attend. The last step in the Settlement approval process is the Fairness Hearing, at which time the Court will hear all evidence and arguments necessary to conclusively evaluate the Settlement to determine whether it is fair, adequate, and reasonable and whether final approval is warranted.

You and/or an attorney you hire at your own expense may, but do not have to, appear at the Fairness Hearing to talk to the Court about your objections. Class Members or their attorneys intending to make an appearance at the Fairness Hearing, pursuant to their written objection, must do the following **no later than 14 days prior to the Fairness Hearing**:

- (a) File a notice of intention to appear with the Court;
- (b) Deliver to Class Counsel and Defendants' Counsel at the addresses above a copy of such notice of intention; and
- (c) Identify any documents they will seek to introduce or witnesses they intend to call at the Fairness Hearing.

Other matters to be considered at the Fairness Hearing will be a determination as to whether an Order Granting Final Approval of the Settlement should be entered, whether the application of Class Counsel for payment of attorneys' fees and expenses should be approved, and any other matters the Court sees fit to address.

How do I get more information?

Go to the Settlement website at www.CRSPensionSettlement.com or call (insert phone number)

for answers to frequently asked questions. You may also contact Current Employees Class Counsel or Retirees Class Counsel at the addresses listed above. Do not contact the Court.

What if my mailing address changes?

If your address changes, you must provide your updated address to the Settlement Administrator in writing at **[insert]**. The Settlement Administrator is responsible for issuing Notice to the Class Members.

5578020.2

EXHIBIT THREE

ANTHEM BOOKLETS
FOR CITY RETIREES

MEDICAL BENEFIT BOOKLET

For

CITY OF CINCINNATI RETIREES

Administered By



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

If You need assistance in Spanish to understand this document, You may request it for free by calling Customer Service at the number on Your Identification Card.

Effective 1-1-2014

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the health care plan (the "Plan") offered by Your Employer. You should read this booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact Your Employer's Group Health Plan Administrator or call the Claims Administrator's Customer Service Department.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The health care services are subject to the Limitations and Exclusions, Copayments, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

Anthem Blue Cross and Blue Shield, or "Anthem" dba Anthem Blue Cross and Blue Shield has been designated by Your Employer to provide administrative services for the Employer's Group Health Plan, such as claims processing, care management, and other services, and to arrange for a network of health care providers whose services are covered by the Plan.

Important: This is not an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

Verification of Benefits

Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Customer Service with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 7:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. CALL THE CUSTOMER SERVICE NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.

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MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have certain rights and responsibilities when receiving Your health care. You also have a responsibility to take an active role in Your care. As Your health care partner, the Claims Administrator is committed to making sure Your rights are respected while providing Your health benefits. That also means giving You access to the Claims Administrator's Network Providers and the information You need to make the best decisions for Your health and welfare.

These are Your rights and responsibilities:

You have the right to:

- Speak freely and privately with Your doctors and other health providers about all health care options and treatment needed for Your condition. This is no matter what the cost or whether it's covered under Your Plan.
- Work with Your doctors in making choices about Your health care.
- Be treated with respect and dignity.
- Expect us to keep Your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information You need to help make sure You get the most from Your health plan, and share Your feedback. This includes information on:
 - The Claims Administrator's company and services.
 - The Claims Administrator's network of doctors and other health care providers.
 - Your rights and responsibilities.
 - The rules of Your health care plan.
 - The way Your health plan works.
- Make a complaint or file an appeal about:
 - Your Plan
 - Any care You get
 - Any Covered Service or benefit ruling that Your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care You may get in the future. This includes the right to have Your doctor tell You how that may affect Your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional provider about the cause of Your illness, Your treatment and what may result from it. If You don't understand certain information, You can choose a person to be with You to help You understand.

You have the responsibility to:

- Read and understand, to the best of Your ability, all information about Your health benefits or ask for help if You need it.
- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician (doctor), also called a PCP, if Your health care plan requires it.
- Treat all doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with Your health care Providers. Call their office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your doctors or other health care Providers to make a treatment plan that You all agree on.
- Follow the care plan that You have agreed on with Your doctors or health care Providers.

- Give the Claims Administrator, Your doctors and other health care professionals the information needed to help You get the best possible care and all the benefits You are entitled to. This may include information about other health and insurance benefits You have in addition to Your coverage with the Plan.
- Let the Claims Administrator's customer service department know if You have any changes to Your name, address or family members covered under Your Plan.

The Claims Administrator is committed to providing quality benefits and customer service to its Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Member Rights and Responsibilities statement.

If You need more information or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your ID card.

How to Obtain Language Assistance

Anthem is committed to communicating with our members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our Customer Service Call Centers. Simply call the Customer Service phone number on the back of Your ID card and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting customer service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the Definitions and Claims Payment sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

Schedule of Benefits	Network	Out-of-Network
Calendar Year Deductible		
Individual	\$0	\$0
Family – All eligible Members combined	\$0	\$0
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)		
Plan Pays	80%	50%
Member Pays	20%	50%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out of Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		
Out-of-Pocket Maximum Per Calendar Year		
Includes Coinsurance. Does NOT include Copayments, precertification penalties, charges in excess of the Maximum Allowed Amount, Non-Covered Services, services deemed not medically necessary, pharmacy claims and human organ and tissue transplants.		
Individual	\$500	\$1,000
Family – All eligible Members combined	\$1,000	\$2,000
The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined.		

Benefits	Network	Out-of-Network
Allergy Care		
<ul style="list-style-type: none"> Testing and Treatment 	20%	50%
Behavioral Health / Substance Abuse Care		
Hospital Inpatient Services	20%	50%
Outpatient Services	20%	50%
Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.		
Clinical Trials Please see Clinical Trials under Benefits section for further information.	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Dental, Oral Surgery and TMJ Services		
<ul style="list-style-type: none"> Accidental Injury to natural teeth Treatment must be completed within 12 months of the Injury) 	20%	50%
<ul style="list-style-type: none"> Oral Surgery and TMJ 	20%	50%
Diagnostic Services	20%	50%
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Care, Urgent Care and Ambulance Services		
Emergency room for a Medical Emergency	20%	20% (See note)
Non-emergency use of the emergency room	Not Covered	Not Covered
Urgent Care clinic visit	20%	20% (See note)
Ambulance Services (when Medically Necessary)	20%	20%
Land / Air		20% (See note)
Note: Care received Out-of-Network for a Medical Emergency will be provided at the Network level of benefits if the following conditions apply: A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm. Care may also be approved as an Authorized Service. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		

Benefits	Network	Out-of-Network
Eye Care (Non-Routine)		
• Office visit – medical eye care exams (treatment of disease or injury to the eye)	20%	50%
• Treatment other than office visit	20%	50%
Hearing Care (Non-Routine)		
• Office visit – Audiometric exam / hearing evaluation test	20%	50%
Home Health Care Services	20%	50%
• Maximum Home Care visits (includes Private Duty Nursing benefit)	Unlimited	30 visits per calendar year
Hospice Care Services	20%	20% (Covered at Network Level)
Hospital Inpatient Services	20%	50%
Maternity Care & Other Reproductive Services		
• Maternity Services	20%	50%
• Infertility services (Benefits only for the diagnosis of Infertility)	20%	50%
• Sterilization Services	20%	50%
Medical Supplies and Equipment		
• Medical Supplies	20%	50%
• Durable Medical Equipment	20%	50%
• Orthotics Foot and Shoe	20%	50%
• Prosthetic Appliances (external)	20%	50%
Nutritional Counseling for Diabetes	20%	50%
Online Visits from LiveHealth Online Provider	20%	Not Covered
Physician Services (Home and Office Visits)	20%	50%
Preventive Services	Covered at 100%	50%
Note: Preventive Services are defined as any claim submitted with a “well” diagnosis.		

Benefits	Network	Out-of-Network	
Skilled Nursing Facility	20%	50%	
Surgical Services	20%	50%	
Therapy Services (Outpatient)			
• Physical Therapy	20%	50%	
• Occupational Therapy	20%	50%	
• Speech Therapy	20%	50%	
• Cardiac Rehabilitation	20%	50%	
• Chiropractic Care	20%	50%	
• Radiation Therapy	20%	50%	
• Chemotherapy	20%	50%	
• Respiratory Therapy	20%	50%	
• Vision Therapy	20%	50%	
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.			
Benefits for physical Therapy and occupational therapy are limited to 60 combined visits per calendar year, combined Network and Out-of-Network.			
Benefits for speech therapy are limited to 20 visits per calendar year, combined Network and Out-of-Network.			
Benefits for chiropractic care are limited to 12 visits per calendar year, combined Network and Out-of-Network.			
Transplants	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, including Medically Necessary preparatory myeloablative therapy.			
• Covered Transplant Procedure during the Transplant Benefit Period(excluding kidney and cornea transplants)	Covered at 100%	50%	50%
• Kidney and Cornea Transplants	NA	20%	50%
• Eligible Travel and Lodging	Covered at 100%	50%	50%

ELIGIBILITY

Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Coverage for the Retiree

This Benefit Booklet describes the benefits an Retiree may receive under this health care Plan. The Retiree is also called a Subscriber.

Coverage for the Retiree's Dependents

If the Retiree is covered by this Plan, the Retiree may enroll his or her eligible Dependents. Covered Dependents are also called Members.

All enrolled eligible, unmarried children will continue to be covered:

1. To the End of the Month in which the child attains age 19; or
2. To the End of the Month in which the child attains age 24 if the child qualifies as a Full-time Student at an accredited school (at least 7 months) and qualifies as a Federal Tax Exemption.

Eligibility will also be continued past the age limit only for those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must notify Us if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, We may require that the Subscriber complete a "Dependency Affidavit" and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

Coverage Effective Dates and enrollment requirements are described in the Group Contract.

Out of Service Area Dependent Child Coverage

Benefits for Covered Services will be provided for enrolled Dependent children who reside outside of the Service Area due to such children attending an out of Service Area educational institution or residing with the Subscriber's former spouse. Benefits are payable at the Network level and are limited to the Maximum Allowable Amount. Payment is subject to any Coinsurance, Copayment and/or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.

If you are eligible to enroll as a Member, you must enroll at the time agreed upon by the Plan. Otherwise, you may only enroll during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

Eligible Dependents (Spouse):

- The Retiree's Spouse. For the purposes of this Plan, a Spouse is defined as a person who is married to a person of the opposite sex from the enrolling Retiree.

Initial Enrollees

Initial Enrollees and eligible Dependents who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Any Employer waiting period which was not satisfied under previous Creditable Coverage must be satisfied under this Plan. However, credit will be given for the length of time already served.

Late Enrollees

If the Retiree or the Retiree's Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, the Retiree or the Retiree's Dependents may be eligible for special enrollment as set out below.

Special Enrollment Periods

There are special enrollment periods for Retirees or Dependents who:

- Originally declined coverage because of other coverage, and
- Exhausted COBRA benefits, lost eligibility for prior coverage, or Employer contributions toward coverage were terminated.

An individual who declined coverage must have certified in writing that he or she was covered by another health plan when he or she initially declined coverage under this Plan in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births or adoptions or placement for adoption. An unenrolled Member may enroll within 31 days of such a special qualifying event.

Important Notes:

- Individuals enrolled during special enrollment periods are **not** Late Enrollees.
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
- Evidence of prior Creditable Coverage is required and must be furnished by the Retiree or the Retiree's prior carrier.

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Retirees and Dependents may also enroll under two additional circumstances:

- the Retiree's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Retiree or Dependent becomes eligible for a subsidy (state premium assistance program)

The Retiree or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Coverage Begins

If the Retiree applies for coverage when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires.

Changing Coverage

There may be an annual re-enrollment period during which time Members may elect to change their options. Retirees and Dependents enrolled in another option may be required to complete an unfulfilled waiting period from prior Creditable Coverage.

Types of Coverage

The types of coverage available to the Retiree are indicated at the time of enrollment through the Employer.

Changing Coverage (Adding a Dependent)

You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Retiree has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

Marriage and Stepchildren

An Retiree may add a Spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If an Retiree does not apply for coverage to add a Spouse and stepchildren within 31 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the “**Late Enrollees**” provision in this section.

Newborn and Adopted Children

You must contact Your Employer within 31 days to add a newborn or adopted child.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final.
 - An “adopted child” is any person under the age of 18 as of the date of adoption or placement for adoption. “Placement for adoption” means the assumption and retention by the Retiree of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Retiree has received an MCSO (a “Medical Child Support Order”) which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order (“QMCSO”).
 - Upon receipt of a QMCSO, the Employer or Plan Administrator will inform the Retiree and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Retiree and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Changing Coverage or Removing a Dependent

When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches terminating age (see “When Coverage Terminates”);
- Enrolled Dependent child becomes totally or permanently disabled.

Portability Provision

Any newly eligible Retiree, Member, enrollee or Dependent who has had similar coverage under another health benefit plan within the previous 63 days is eligible for coverage immediately. The Effective Date of coverage is subject to any length-of-service provision the Employer requires. A newly eligible person is an individual who was not previously eligible for coverage under this Plan.

SUMMARY OF BENEFITS

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

Introduction

Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

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

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

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard." This program lets You get Covered Services at the Network cost-share when You are traveling out of state and need health care, as long as You use a BlueCard Provider. All You have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send Your claims to the Claims Administrator.

If You are out of state and an Emergency or urgent situation arises, You should get care right away.

In a non-Emergency situation, You can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Please refer to **Inter-Plan Programs** in the **Claims Payment** section for more information on BlueCard.

Care Outside the United States – BlueCard® Worldwide

Prior to travel outside the United States, check with Your Group or call Customer Service at the number on your Identification Card to find out if Your Plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we recommend:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your current Identification Card.
- In an emergency, go directly to the nearest Hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- You need to find a Physician or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

- You need to be hospitalized or need Inpatient care. After calling the Service Center, You must also call the Claims Administrator to obtain approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information

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

Claim Filing

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

Claim Forms

International claim forms are available from the Claims Administrator, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.

Calendar Year Deductible

Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits**.

HEALTH CARE MANAGEMENT - PRECERTIFICATION

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to determine when services should be covered by Your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

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

If You have any questions regarding the information contained in this section, You may call the Customer Service telephone number on Your Identification Card or visit www.bcbsga.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, You, Your authorized representative or Physician must notify the Claims Administrator within 2 business days after the admission or as soon as possible within a reasonable period of time. 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.

Predetermination – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. The Claims Administrator will review Your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

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

Failure to Obtain Precertification Penalty:

IMPORTANT NOTE: IF YOU OR YOUR PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, A PENALTY WILL APPLY AND YOUR OUT OF POCKET COSTS WILL INCREASE.

The following list is not all inclusive and is subject to change; please call the Customer Service telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

Inpatient Admission:

- All acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehabilitation, and Obstetrical delivery stays beyond the 48/96 hour Federal mandate length of stay minimum (including newborn stays beyond the mother's stay)
- Emergency Admissions (requires Plan notification no later than 2 business days after admission)

Outpatient Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bariatric surgery
- Bone-Anchored Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction, Mastectomy for Gynecomastia and other Breast Procedures
- Canaloplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation
- Diagnostic Testing
 - Diagnosis of Sleep Disorders
 - Gene Expression Profiling for Managing Breast Cancer Treatment
 - Genetic Testing for Cancer Susceptibility
- DME/Prosthetics
 - Bone Growth Stimulator: Electrical or Ultrasound
 - Communication Assisting / Speech Generating Devices
 - External (Portable) Continuous Insulin Infusion Pump
 - Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
 - Microprocessor Controlled Lower Limb Prosthesis
 - Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
 - Pneumatic Pressure Device with Calibrated Pressure
 - Power Wheeled Mobility Devices
 - Prosthetics: Electronic or externally powered and select other prosthetics
 - Standing Frame
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Implantable or Wearable Cardioverter-Defibrillator (ICD)
- Implantable Infusion Pumps
- Implantable Middle Ear Hearing Aids
- Implanted Devices for Spinal Stenosis
- Implanted Spinal Cord Stimulators
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar spinal surgeries

- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
- Surgical Treatment of Migraine Headaches
- Occipital nerve stimulation
- Orthognathic Surgery
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Back Pain
- Photocoagulation of Macular Drusen
- Physician Attendance and Supervision of Hyperbaric Oxygen Therapy
- Plastic/Reconstructive surgeries:
 - Abdominoplasty, Panniculectomy, Diastasis Recti Repair
 - Blepharoplasty
 - Brachioplasty
 - Buttock/Thigh Lift
 - Chin Implant, Mentoplasty, Osteoplasty Mandible
 - Insertion/Injection of Prosthetic Material Collagen Implants
 - Liposuction/Lipectomy
 - Procedures Performed on Male or Female Genitalia
 - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
 - Procedures Performed on the Trunk and Groin
 - Repair of Pectus Excavatum / Carinatum
 - Rhinoplasty
 - Skin-Related Procedures
- Percutaneous Spinal Procedures
- Private Duty Nursing
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Radiation therapy
 - Intensity Modulated Radiation Therapy (IMRT)
 - Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Thoracoscopy for Treatment of Hyperhidrosis
- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Preventricular Device
- Transtympanic Micropressure for the Treatment of Ménière's Disease

- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admissions for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- All Outpatient services for the following:
 - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
 - Donor Leukocyte Infusion

Mental Health/Substance Abuse (MHSA):

Pre-certification Required

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

Outpatient Therapy

- May be required after the initial twelve (12) visits. Please call the customer service number on Your ID card for details. Generally speaking no precertification is required for this service.

Procedures, equipment, and/or specialty infusion drugs which have Medically Necessary criteria as determined by the Claims Administrator's Corporate Medical Policy or Clinical Guidelines.

Referrals:

Requests for Out of Network Referrals for care that the Claims Administrator determines are Medically Necessary may be pre-authorized, based on network adequacy and Medical Necessity

The ordering Provider, facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification?	
<p>Services provided by a Network Provider, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.</p>	<p>Services provided by BlueCard providers outside the service areas of the states listed in the column to the left, BlueCard providers in other states not listed, and any Out-of-Network/Non-Participating Provider.</p>

<p>Provider is responsible for Precertification.</p>	<ul style="list-style-type: none"> • Member is responsible for Precertification. • Member is financially responsible for service and/or setting that are not covered under this Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative.
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The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making Medical Necessity decisions. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Employer's Group Health Plan Document takes precedence over these guidelines.

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

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

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

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

You may determine whether a Provider is participating in certain programs by contacting the customer service number on the back of your ID card.

Request Categories:

- **Urgent** – A request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.
- **Prospective** – A request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on Your membership card for additional information.

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

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

The Claims Administrator will provide notification of its decision in accordance with federal regulations.

Notification may be given by the following methods:

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

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

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date You receive service:

1. You must be eligible for benefits;
2. the service or surgery must be a covered benefit under Your Plan; and
3. the service cannot be subject to an exclusion under Your Plan
4. You must not have exceeded any applicable limits under Your Plan.

Individual Case Management

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

The Claims Administrator's Case Management programs are confidential and voluntary. These programs are given at no extra cost to You.

If You meet program criteria and agree to take part, the Claims Administrator will help You meet your identified health care needs. This is reached through contact and team work with You and/or your chosen representative, treating Doctor(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service through the Claims Administrator's Case Management program. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator will make its decision case-by-case, if in the Claims Administrator's discretion the alternate or extended benefit is in the best interest of the Member and the Plan. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify You or your representative in writing.

BENEFITS

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

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

Ambulance Service

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

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

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

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Assistant Surgery

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

Behavioral Health Care and Substance Abuse Treatment

See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or Outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Hospital Inpatient Care

Benefits for Inpatient Hospital and Physician charges are Covered Services.

Professional Outpatient Care

Covered Services include:

- Professional care in the Outpatient department of a Hospital;
- Physician's office visits; and
- Services within the lawful scope of practice of a licensed, approved provider.

Note: To be reimbursable, care must be given by a psychiatrist, psychologist, neuropsychologist, or a mid-level provider such as a licensed clinical social worker, mental health clinical nurse specialist, a marriage and family therapist, or a licensed professional counselor.

Breast Cancer Care

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

Breast Reconstructive Surgery

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

Cardiac Rehabilitation

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

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

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

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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

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

Consultation Services

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

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

Dental Services

Related to Accidental Injury

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

Treatment must be completed within the timeframe shown in the Schedule of Benefits.

Other Dental Services

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- The Member is under the age of five (5);
- The Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes

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

Dialysis Treatment

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

Durable Medical Equipment

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

The equipment must meet the following criteria:

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

Emergency Care

Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for a life-threatening condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or cause serious harm.

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

General Anesthesia Services

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

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

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

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

Home Health Care Services

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

Some special conditions apply:

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

Covered Services:

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

Covered Services for Home Health Care do not include:

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

Hospice Care Services

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that You are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Benefit Booklet.

Hospital Services

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

Network

Inpatient Services

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

Service and Supplies

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

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the "**Schedule of Benefits**" section.

Outpatient Hospital Services

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

Hospital Visits

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

Human Organ and Tissue Transplant Services

Notification

To maximize your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

Contact the customer service telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or benefit booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Claims Administrator for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Out-of-Network Transplant Provider Facility.

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 transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Licensed Speech Therapist Services

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

Maternity Care & Infertility Services

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

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

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.)

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

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

Infertility Services

Your Plan also includes benefits for the diagnosis of Infertility.

Medical Care

General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

Nutritional Counseling

Nutritional counseling related to the medical management of a disease state as stated in the Schedule of Benefits.

Out-of-Network Freestanding Ambulatory Facility

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

Out-of-Network Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the “**Schedule of Benefits**” section.

Obesity

Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan. Precertification is required, and coverage is only provided for gastric bypass, vertically banded gastroplasty and adjustable gastric banding procedure (lap band).

Online Visits

When available in Your area, Your coverage will include online visit from a LiveHealth Online Provider. Covered services include a medical consultation using the internet via a webcam, chat or voice. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Online visits are not covered from Providers other than those contracted with LiveHealth Online. Non Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification;
- Physician to Physician consultation.

Oral Surgery

Covered Services include only the following:

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

Other Covered Services

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

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

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Outpatient Surgery

Network Hospital Outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under "Hospital Services".

Physical Therapy, Occupational Therapy, Chiropractic Care

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

Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements.

Preventive Care

Covered Services in the Physician's or Specialist Physician's office or independent lab include, but are not limited to:

- Treatment or preventive services including periodic health examinations for adults and Dependent children. Employment or insurance-related physicals are not covered;
- Well child care;
- Preventive lab and x-ray;
- Immunizations;
- Flu injections;
- Gynecological (well woman) exams;
- Annual Pap smear;
- Annual prostate screening;
- Annual routine mammogram (also covered in the Hospital setting);
- Colorectal cancer screening including fecal occult blood test, sigmoidoscopy, and colonoscopy;
- Audiometric exams; and
- Routine eye exams.

Prosthetic Appliances

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

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

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

Reconstructive Surgery

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

Reconstructive surgery is covered only to the extent Medically Necessary:

- to correct significant anatomic deformities which are not within normal anatomic variation and which are caused by congenital or developmental abnormalities, illness, or Injury for the purpose of improving the significant anatomic deformity toward a normal appearance; or

- to correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Retail Health Clinic

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

Skilled Nursing Facility Care

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

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

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

- semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

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

Benefits will not be provided when:

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

Surgical Care

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

Treatment of Accidental Injury in a Physician's Office

All Outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit if services are rendered by a Network Provider; services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

LIMITATIONS AND EXCLUSIONS

The following section indicates items, which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items, which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.
2. Services for Custodial Care. Services for custodial or convalescent care, rest cures or long-term custodial Hospital care.
3. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
4. Charges for treatment received before coverage under this option began or after it is terminated.
5. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated.
6. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.
7. Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
8. Shoe inserts, orthotics (will be covered if prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary).
9. Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
10. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Participant has enrolled in Medicare Part B.
11. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
12. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.

13. Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Although coverage for Outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.
14. 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.
15. Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
16. Vitamins, minerals and food supplements, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.
17. Services for Hospital confinement primarily for diagnostic studies.
18. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury or to correct a congenital defect.
19. Donor Search/Compatibility, except as otherwise indicated.
20. Hearing aids, hearing devices or examinations for prescribing or fitting them.
21. Contraceptive drugs, except for any above stated covered contraceptive devices.
22. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
23. Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this Benefit Booklet.
24. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
25. Christian Science Practitioner Services.
26. Smoking Cessation Products including gum, patches and prescription drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.
27. Services provided in a Residential Treatment Center (RTC).
28. Services provided in a Halfway House.
29. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.

30. Routine care services, unless specified in this Benefit Booklet.
31. Services or supplies provided by a member of your family or household.
32. Charges or any portion of a charge in excess of the Allowed Amount as determined by the Claims Administrator.
33. Fees or charges made by an individual, agency or facility operating beyond the scope of its license.
34. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
35. Services for any form of telecommunication
36. Charges for any of the following:
 - a. Failure to keep a scheduled visit;
 - b. Completion of claim forms or medical records or reports unless otherwise required by law;
 - c. For Physician or Hospital's stand-by services;
 - d. For holiday or overtime rates.
 - e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
 - f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
37. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.
38. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
39. Surgical care or medical treatment or study related to the modification of sex (transsexualism) and related services, or the reversal thereof.
40. Reversal of vasectomy or reversal of tubal ligation.
41. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes.
42. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.
43. Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e. diabetes.
44. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
45. Services for weight loss programs, services and supplies. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss).

CLAIMS PAYMENT

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the BlueCard® PPO Network Hospitals, Physicians and Ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by contacting Your local Human Resources Department or by visiting www.bcbsga.com.

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

How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within 12 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

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

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

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

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

Maximum Allowed Amount

General

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

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

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;

- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Plan.

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

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

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

Provider Network Status

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

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

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

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

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

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

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

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

Member Cost Share

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

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

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

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist

who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

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

Services Performed During Same Session

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

Processing Your Claim

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

Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary Information

In order to process Your claim, the Claims Administrator may need information from the provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other provider to release necessary information.

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

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 for ERISA plans, information regarding the right to bring an action after the Appeals process.

Inter-Plan Programs

Out-of-Area Services

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

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

BlueCard® Program

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

Whenever You access covered healthcare services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

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

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

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

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

You will be entitled to benefits for healthcare services that You accessed either inside or outside the geographic area Anthem serves, if this Booklet covers those healthcare services. Due to variations in Host Blue network protocols, You may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though You might not otherwise have been entitled to benefits if You had received those healthcare services inside the geographic area Anthem. But in no

event will You be entitled to benefits for healthcare services, wherever You received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

Non-Participating Healthcare Providers Outside Anthem's Service Area

Member Liability Calculation

When covered healthcare services are provided outside of the Claims Administrator's Service Area by non-participating healthcare providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Administrator would make if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Administrator will pay for services rendered by nonparticipating healthcare providers. In these situations, You may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

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 Out-of-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.bcbsga.com for more information about such arrangements.

Unauthorized Use of Identification Card

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

Assignment

You authorize the Claims Administrator, on behalf of the Employer, 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 Federal law.

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

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

Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Customer Service Department. Be sure to always give Your Member Identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- provider name and address (Hospital or Physician).

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

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

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

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

YOUR RIGHT TO APPEAL

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

- A pre-service claim is a claim for benefits under the plan for which You have not received the benefit or for which You may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which You have received the service.

If Your claim is denied or if Your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

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

Notice of Adverse Benefit Determination

If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA if You appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist You

For claims involving urgent/concurrent care:

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

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent

with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

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

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

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

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

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

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

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

How Your Appeal will be Decided

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

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care

professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

If Your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If You are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If You would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to You and it was based on medical judgment, You may be eligible for an independent External Review pursuant to federal law.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

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

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

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

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

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this health care plan. There is no charge for You to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If Your health benefit plan is sponsored by Your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

COORDINATION OF BENEFITS (COB)

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

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

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

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

COB DEFINITIONS

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

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

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

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

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

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

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

The following are non Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount that is subject to the Primary high-Deductible health plan's Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

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

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

ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

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

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

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

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

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
 - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the Spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

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

rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering You as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own Plan as an employee, member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a Dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a Dependent of an employee, member, subscriber or retiree).

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

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

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

SUBROGATION AND REIMBURSEMENT

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

Recovery

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

Subrogation

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

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

1. the amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
 2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
 - The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
 - The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal Injury or illness to You occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.

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

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

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

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

GENERAL INFORMATION

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Claims Administrator by the Employer, and any and all statements made to the Employer by the Claims Administrator, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Circumstances Beyond the Control of the Plan

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

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the 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 Your Identification Card.

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member 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 or equivalent employer liability or indemnification law.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under

any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Medicare Program

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

- **If You Are Under Age 65 With End Stage Renal Disease (ESRD)**
If You are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This includes the Medicare "three month waiting period" and the additional **30 months** after the Medicare effective date. After 33 months, the benefits described in this Benefit Description will be reduced by the amount that Medicare allows for the same *Covered Services*.
- **If You Are Under Age 65 With Other Disability**
If You are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This is the case **only** if You are the actively employed *Subscriber* or the enrolled Spouse or child of the actively employed Subscriber.
- **If You Are Age 65 or Older**
If You are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Description before Medicare. This can be the case **only** if You are an actively employed Subscriber or the enrolled Spouse of the actively employed Subscriber.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in Your Explanation of Benefits is the final determination and You will not receive notice of an adjusted cost share amount as a result of such recovery activity.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. The Claims Administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Claims Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator may not provide You with notice of overpayments made by the Plan or You if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Employer-Member-Claims Administrator)

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

The Employer is fiduciary agent of the Member. The Claims Administrator's notice to the Employer will constitute effective notice to the Member. 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 Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

Anthem Note

The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and Anthem and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Ohio. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business; to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications or Changes in Coverage

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Acts Beyond Reasonable Control (Force Majeure)

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

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

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

Policies and Procedures

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

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

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under Your Employer's Group health Plan and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Waiver

No agent or other person, except an authorized 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.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Governmental Health Care Programs

Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group

benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

WHEN COVERAGE TERMINATES

Termination of Coverage (Individual)

Membership for You and Your enrolled family members may be continued as long as You are employed by the Employer and meet eligibility requirements. It ceases if Your employment ends, if You no longer meet eligibility requirements, if the Plan ceases, or if You fail to make any required contribution toward the cost of Your coverage. In any case, Your coverage would end at the expiration of the period covered by Your last contribution.

Coverage of an enrolled child ceases at the end of the month the child attains the age limit shown in the Eligibility section. Coverage of a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Should You or any family Members be receiving covered care in the Hospital at the time Your membership terminates for reasons other than Your Employer's cancellation of this Plan, or failure to pay the required Premiums, benefits for Hospital Inpatient care will be provided until the date You are discharged from the Hospital.

Certification of Prior Creditable Coverage

If Your coverage under this Plan is terminated, You and Your covered Dependents will receive a certification that shows Your period of coverage under this health benefit plan. You may need to furnish the certification if You become eligible under another group health plan. You may also need the certification to buy, for yourself or Your family, an individual policy that does not exclude coverage for medical conditions that were present before Your enrollment. You and Your Dependents may request a certification within 24 months of losing coverage under this health benefit plan.

You may also request a certification be provided to You at any other time, even if You have not lost coverage under this plan. If You have any questions, contact the customer service telephone number listed on Your Identification Card.

Continuation of Coverage (Federal Law-COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with federal law. If Your employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when Your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your Spouse and Your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of Your family who is enrolled in the company's employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<p><u>For Retirees:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked</p>	18 months
<p><u>For Spouses/ Dependents:</u> A Covered Retiree's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked</p> <p>Covered Retiree's Entitlement to Medicare</p> <p>Divorce or Legal Separation</p> <p>Death of a Covered Retiree</p>	<p>18 months</p> <p>36 months</p> <p>36 months</p> <p>36 months</p>
<p><u>For Dependents:</u> Loss of Dependent Child Status</p>	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if You become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for Your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

If You are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage, You will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event

If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, Your Spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused Your Spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, You or an eligible family member must make an election within 60 days of the date Your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies You or Your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage You choose to continue. If the Premium rate changes for active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If You don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused You to be eligible initially for COBRA coverage under this Plan, You will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which You become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 72.5% of the cost for health coverage for You and Your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount You have to pay out of pocket.

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to You, You may continue COBRA coverage only until these limitations cease;
- a covered individual becomes entitled to Medicare after electing COBRA; or
 - the Group terminates all of its group welfare benefit plans.

Continuation of Coverage During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the

military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact 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.

DEFINITIONS

Accidental Injury

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

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.

Ambulance Services

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

Authorized Service(s)

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

Behavioral Health Care

Includes services for Mental Health Disorders, and Substance Abuse.

Mental Health Disorders

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

Substance Abuse or Chemical Dependency

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

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

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

Benefit Period

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

Centers of Excellence (COE) Network

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

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

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Community Insurance Company was chosen to administer this Plan. 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 80%, then the remaining 20% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

Combined Limit

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

Complications of Pregnancy

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

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

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

Congenital Anomaly

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

Coordination of Benefits

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

Cosmetic Surgery

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease

state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Creditable Coverage

Coverage under another health benefit plan is medical expense coverage with no greater than a 63 day gap in coverage under any of the following: (a) Medicare or Medicaid; (b) an employer-based accident and sickness insurance or health benefit arrangement; (c) an individual accident and sickness insurance policy; (d) a Spouse's benefits or coverage under Medicare or Medicaid or an employer-based health insurance benefit arrangement; (e) a conversion policy; or (f) similar coverage. The Claims Administrator will issue a certificate of Creditable Coverage upon request or when a Member leaves the Plan. Call the Customer Service number on Your Identification Card to request such a certificate.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible

The portion of the bill You must pay before Your medical expenses become Covered Services.

Dependent

The Spouse and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Mentally

retarded or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

Detoxification

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

Developmental Delay

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

Durable Medical Equipment

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

Effective Date

The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

Elective Surgical Procedure

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

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

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 determines to be unproven.

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

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or

- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

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

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

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

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

Freestanding Ambulatory Facility

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

Group Health Plan or Plan

An employee welfare benefit plan (as defined in Section 3(1) of ERISA, established by the Employer, in effect as of the Effective Date.

Health Plan Document

This Benefit Booklet in conjunction with the Health Plan Document, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Health Plan Document and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Health Plan Document, the Health Plan Document shall control.

Home Health Care

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

Home Health Care Agency

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

Hospice

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

Hospice Care Program

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

Hospital

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

- an extended care facility; nursing home; place for rest; facility for care of the aged;

- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

Identification Card

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

Ineligible Charges

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

Ineligible Provider

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

Infertile or Infertility

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

Initial Enrollee

A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury

Bodily harm from a non-occupational accident.

Inpatient

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

Intensive Care Unit

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

Late Enrollees

Late Enrollees mean Retirees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

Maternity Care

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

Maximum Allowed Amount

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

Medical Emergency

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

Medical Facility

A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit booklet. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Claims Administrator.

Medical Necessity or Medically Necessary

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 Member'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 Member 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 always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

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 or a Covered Service and **does not** guarantee payment.

Member

Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

Network Provider

A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements.

New Hire

A person who is not employed by the Employer on the original Effective Date of the Plan.

Non-Covered Services

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

Out-of-Network Provider

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

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

Out-of-Pocket Maximum

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

Physical Therapy

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

Physician

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

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Administrator

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

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Primary Care Physician

A provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization

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

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Retiree is entitled under the plan; and includes the name and last known address of the Retiree and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a group health plan Member or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

Retail Health Clinic

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

Retiree

A person who was engaged in active employment with the Employer and is eligible for Plan coverage under the retirement regulations of the Employer. The Retiree is also called the Subscriber.

Semiprivate Room

A Hospital room which contains two or more beds.

Skilled Convalescent Care

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

Skilled Nursing Facility

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

Spouse

For the purpose of this Plan, a Spouse is defined as a person who is married to a person of the opposite sex from that of the enrolling Retiree.

Therapeutic Equivalent

Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

Transplant Providers

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

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

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

Urgent Care

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

Utilization Review

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

You and Your

Refer to the Subscriber, Member and each Covered Dependent.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Grandfathered Health Plan

This Plan believes this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator or Your Employer.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

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

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

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

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

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

If You would like more information on WHCRA benefits, call Your Plan Administrator.

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

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

Mental Health Parity and Addiction Equity Act

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

Special Enrollment Notice

If You are declining enrollment for yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, provided that You request enrollment within 31 days after Your other coverage ends.

In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll yourself and Your Dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Retirees and Dependents may also enroll under two additional circumstances:

- the Retiree’s or Dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Retiree or Dependent becomes eligible for a subsidy (state premium assistance program)

The Retiree or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Customer Service telephone number on Your ID Card, or contact Your Plan Administrator.

The Anthem National Accounts business unit serves members of: Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California using the trade name Anthem Blue Cross in California; using the trade name of Anthem Blue Cross and Blue Shield for the following companies in: Colorado Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Connecticut: Anthem Health Plans, Inc.; Georgia: Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.; Indiana: Anthem Insurance Companies, Inc.; Kentucky: Anthem Health Plans of Kentucky, Inc.; Maine: Anthem Health Plans of Maine, Inc.; Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits; Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada.; New Hampshire: Anthem Health Plans of New Hampshire, Inc.; Ohio: Community Insurance Company; Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123.; Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. In 28 eastern and southeastern counties in New York, Empire Blue Cross Blue Shield, the trade name of Empire HealthChoice Assurance, Inc., underwrites and/or administers the PPO, EPO, POS and indemnity policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.