Anthem BlueCross

Prescription Drug Certificate of Coverage

(Herein called the "Certificate")

Senior Rx Plus

Please Read Your Certificate Carefully

Claims Administration provided by Anthem Blue Cross Life and Health Insurance

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

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Introduction

This plan is offered by your Employer, and claims under this plan are administered by Anthem Blue Cross Life and Health Insurance (Anthem) on behalf of your Employer. Anthem is referred to throughout the Certificate as "We," "Us," or "Our." Senior Rx Plus is referred to as "plan" or "your plan."

This Certificate (sometimes called Evidence of Coverage) is the legal document explaining your benefits. Please read this Certificate carefully, and refer to it whenever you require prescription drug services.

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

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

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

If you have any questions about this Certificate, please call the Customer Service number located on the back of your Membership Card (sometimes called Identification Card).

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

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BENEFIT CHART

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

Benefit Period	**January 1, 2013 – December 31, 2013**
Covered Services	**What you pay**
After benefits have been paid by your Group Part D Plan and this Plan for covered drugs, you will be responsible for the amounts shown below.	
Retail Pharmacy	per 30-day supply
• Generics, including Specialty Drugs	$10 copay
• Preferred Brands, including Specialty Drugs and Vaccines	$30 copay
• Non-Preferred Brands and Non-Formulary Drugs	$45 copay
• Diabetic Supplies – insulin syringes • Diabetic Supplies – alcohol swabs and gauze	$30 copay $0 copay
Typically retail pharmacies dispense a 30-day supply of medication. Some of our retail pharmacies can dispense up to a 90-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays. If you purchase more than a 30-day supply at one of the University of California retail pharmacies, you only pay the mail order copay shown below.	
Mail Order Pharmacy	per 90-day supply
• Generics, including Specialty Drugs	$20 copay
• Preferred Brands, including Specialty Drugs and Vaccines	$60 copay
• Non-Preferred Brands and Non-Formulary Drugs	$90 copay
• Diabetic Supplies – insulin syringes • Diabetic Supplies – alcohol swabs and gauze	$60 copay $0 copay

Covered Services	What you pay
Extra Covered Drugs - California	
These are drugs that are covered on plans issued in California. These drugs are often excluded from Part D Plans. These drugs will be covered under both your Group Part D Plan and this Plan.	
Contraceptive Devices	Limit 1 per year; Copay or coinsurance per Covered Device
• Prescription	$0 copay

- When a member's physician has specified "dispense as written" (DAW) for non-preferred brand name drugs or non-formulary drugs, the copay for preferred brand name formulary drugs will apply.
  When a member's physician has not specified DAW for non-preferred brand name drugs or non-formulary drugs, the Tier 3 copay will apply.

- Once the cost you have paid for covered drugs reaches $1,000 your plan will cover 100% of the cost of covered drugs. You will no longer have to pay a copay or coinsurance for covered drugs.

Outpatient Prescription Drug Benefits

This Plan supplements the benefits paid by the Group Part D Plan you also have through the Retiree's former employer. This section describes the benefits available under this Plan.

Your Group Part D Plan is the primary payer plan, and this Plan will supplement benefits provided by that Plan. If your Group Part D Plan covers an Outpatient Drug, then this Plan will supplement benefits paid by your Group Part D Plan up to, but not including, your Coinsurance or Copay amount shown in the benefit chart in this Certificate.

Except for the coverage provided under the **"Out of Country Medical Emergency Drug"** benefit in this Certificate, your Group Part D Plan will determine whether a drug you are taking will be covered or whether coverage will be subject to any quantity limit, prior authorization or step therapy restrictions.

If your Group Part D Plan includes a deductible, this Plan will not supplement your Group Medicare Plan deductible.

General Information

Coinsurance/Copayment

The coinsurance or copayment amount shown in the benefit chart in this Certificate is the amount you will have to pay for Covered Drugs after your Group Part D Plan and this Plan have paid benefits. A separate coinsurance or copayment will apply to each covered drug that you fill when you go to a Pharmacy. When you owe a flat copayment, your Prescription Drug copayment will be the lesser of your Plans' copayment amount or the Maximum Allowable Amount for the covered drug.

Tiers

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

This Plan and your Group Part D Plan cover the same drugs in each drug plan tier. The types of drugs covered by your Plans in each tier are shown in the benefit chart in the front of this Certificate.

You can find out which tier a specific covered drug is covered at by checking your Group Part D Plan's Formulary (Drug List).

Benefits for Out of Country Medical Emergency Drugs

This Plan provides benefits for outpatient drugs not covered by your Group Part D Plan when all of the following apply:

1) You are traveling outside the 50 United States, District of Columbia, and Puerto Rico for less than 6 months,
2) You remain a permanent resident of the United States while you are out of country,
3) You require the outpatient drug(s) to treat a Medical Emergency condition,

4) The drug is approved by the FDA, and
5) The drug would be determined to be a covered drug by your Group Part D Plan if the drug was filled by a pharmacy located within the United States.

When you receive benefits for outpatient prescription drugs to treat an out of country medical emergency condition, you will need to pay the full cost of the drug and request that we reimburse you for our share. Your share of a covered outpatient drug will be your coinsurance or copayment amount plus the difference between what the out of country pharmacy charged for your covered outpatient drug and the Maximum Allowable Amount. Please see **"How to Obtain Prescription Drug Benefits"** for complete directions.

How to Obtain Prescription Drug Benefits

Your Membership Card covers both your Group Part D Plan and this Plan. Just give the pharmacist your Membership Card when you get your prescription filled. We will process benefits under both your Group Part D Plan and this Plan automatically. So long as your drug is covered under your Group Part D Plan, the drug will be treated as covered under this Plan. You do not need to take any additional steps to obtain the supplemental benefits under this Plan.

Additionally, if you receive outpatient drugs from a pharmacy that does not have a contract with us including outpatient drugs covered under this Plan's **"Out of Country Medical Emergency Drug"** benefit, you will need to pay the full cost of your outpatient drug(s). You can ask us to reimburse you for our share of the cost.

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

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it's helpful for your plan to process the information faster.

Please contact Customer Service at the number on the back of your Membership Card.

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

Senior Rx Plus
P.O. Box 110
Fond du Lac, Wisconsin 54936

Please be sure to contact Customer Service if you have any questions. If you don't know what you owe, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

Non-Covered Services/Exclusions

This Plan supplements the benefits paid by the Group Part D Plan you also have through the Retiree's former employer.

This Plan does not provide benefits:

1) For drug costs not covered by your Group Part D Plan, except costs for drugs covered under the **"Out of Country Medical Emergency Drug"** benefit.
2) For drugs covered under Medicare Part A or Part B.
3) For costs you pay toward meeting your Group Part D Plan deductible, if you have one.

Coordination of Benefits

Medicare

Any benefits covered under both this Certificate and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate provisions, and federal law.

The benefits under this Certificate for Members age 65 and older, or otherwise eligible for Medicare, do not duplicate any prescription benefit for which members are entitled under Medicare, including Parts B and/or D. We will reduce our payment under this Plan by the amount you are eligible to receive for the same service under Medicare or under any other federal, state or local government programs, unless the government program benefits are by law excess to any private insurance or other non-governmental program. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to members shall be reimbursed by or on behalf of the members to the Plan, to the extent the Plan has made payment for such services. No prescription drug benefits will be payable under this Certificate unless you are enrolled in the Group Medicare Part D Plan or Group Medicare Advantage Prescription Drug Plan available as part of the Group Retiree Benefit Plans offered by the Retiree's former employer.

Non-Medicare

If you're covered by this group health plan, and one or more other medical plans, total benefits may be limited as shown below. These provisions apply separately each calendar year to each person.

Definitions

When used in this section, the following words and phrases have the meanings explained here.

Allowed Expense is any needed, reasonable and customary item of expense which is at least partially covered by at least one Other Plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

Each contract or arrangement for coverage listed above will be considered a separate plan. The rules of these provisions will apply only when the other plan has coordination of benefits provisions.

Primary Plan is the plan which will have its benefits figured first.

This Plan is the part of this *plan* that provides benefits subject to this provision.

Effect on Benefits

This provision will apply in determining a person's benefits under This Plan for any *calendar* year if the benefits under This Plan and any Other Plans, exceed the Allowable Expenses for that *calendar* year.

1. If This Plan is the primary plan, then we will figure out its benefits first without taking into account any other plan.
2. If This Plan isn't the primary plan, then we may reduce its benefits so that the benefits of all the plans aren't more than the Allowed Expense.
3. The benefits of This Plan will never be more than the benefits we would have paid if you were covered only under this *plan*.

Order of Benefits Determination

The following rules determine the order in which benefits will be paid:

1. A plan with no coordination provision will pay its benefits first.
2. A plan which covers you through your employer pays before a plan which covers you as a family member. But if you have Medicare and are also a dependent of an active employee under another employer plan, this rule might change. If Medicare's rules say that Medicare pays after the plan that covers you as a dependent but before your employer's plan, then the plan that covers you as a dependent pays before a plan which covers you through your employer. This might happen if you are covered under This Plan as a retiree.
3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the year. But if one plan doesn't have a birthday rule provision, that plan's provisions will determine the order of benefits.

   Exception to rule 3: If a dependent child's parents are divorced or separated, the following rules will be used instead of rule 3:

   a. The plan of the parent who has custody, will pay first, unless he or she has remarried.

   b. If the parent with custody has remarried, then the order is as follows:

      i. The plan which covers that child as a dependent of the parent with custody.

      ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

      iii. The plan which covers that child as a dependent of the parent without custody.

      iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

   c. However, if there is a court decree which holds one parent responsible for that child's health care coverage, the plan which covers that child as a dependent of the responsible parent pays first.

4. The plan covering you as a laid-off or retired employee or as such employee's dependent pays after another plan covering you. But if either plan doesn't have a rule about laid-off or retired employees, rule 6 applies.
5. A plan covering you under a state or federal continuation of coverage pays after another plan. However, if the other plan doesn't have this rule, this rule won't apply.
6. When the rules above don't apply, the plan that has covered you longer pays first unless two of the plans have the same effective date. In this case, Allowed Expense is split evenly between the two plans.

Plan's Rights Under This Provision

Responsibility For Timely Notice. We aren't responsible for coordination of benefits unless we get information from the asking party.

Reasonable Cash Value. If you get benefits from another plan in the form of services, the value of services in cash will be considered allowed expense and a benefit paid.

Facility of Payment. If another plan pays benefits that this plan should have paid, we will pay the other plan an amount determined by us. This will be considered a benefit paid under this plan, and will fully satisfy what we are responsible for.

Right of Recovery. If we pay benefits that are more than we should have paid under this provision, we may recover the extra amounts from one or more of the following:

- The persons to or for whom payments were made;
- Insurance companies or service plans; or
- Other organizations.

Eligibility and Enrollment

You must satisfy certain requirements to participate in this Plan. We describe general eligibility requirements in this Certificate. Please contact your Human Resources or Benefits Department if you have questions regarding your or your dependent's eligibility for the Group Retiree Benefit Plan options offered by the Retiree's former employer.

Eligibility

To be eligible to enroll under this Certificate you must:

- Be a Retiree or Dependent of the Retiree of the Employer
- Be entitled to participate in the Retiree Benefit Plan arranged by the Employer
- Be entitled to Medicare Part A and/or enrolled in Medicare Part B
- Be enrolling in or enrolled in the Group Part D Plan (Part D or Medicare Advantage Prescription Drug Plan) that is also part of the Group Retiree Benefit Plan arranged by the Retiree's former Employer for Medicare-eligible retirees and their Medicare-eligible dependents
- Live in the service area in which we can provide retired group members access to participating pharmacies. Our service area includes all 50 United States, the District of Columbia and Puerto Rico.

  We cannot service retirees or their dependents if they live outside the 50 United States, District of Columbia or Puerto Rico. If you plan to move out of the service area, please contact Customer Service or your Human Resources or Benefits Department.

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

- The Covered Retiree's or the Covered Retiree's spouse's children, including natural children, stepchildren, and legally adopted children and children who the Employer has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- Children for whom the Covered Retiree or the Covered Retiree's spouse is a legal guardian or as otherwise required by law.

This non-Medicare Retiree Drug Plan is part of the Group Retiree Benefit Plan offering for Retirees and their Dependents that are Medicare-eligible. Please contact your Human Resources or Benefits Department if you need information on Group Retiree Benefit Plan options for yourself or your dependents who are not Medicare-eligible.

Enrollment

An Eligible Retiree or Dependent must meet all eligibility requirements to enroll.

Initial Enrollment

An eligible Retiree or Dependent can enroll for coverage under this Certificate when they first become eligible for this Plan. You must submit your complete application for enrollment. You can enroll in this Plan when you are first eligible, if you are already enrolled in or are concurrently enrolling in the Group Part D Plan that is also part of the Group Retiree Benefit Plan arranged by the Retiree's former Employer for Medicare-eligible Retirees and their Medicare-eligible Dependents.

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

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

This non-Medicare Retiree Drug Plan is part of the Group Retiree Benefit Plan offering for Retirees and their Dependents that are Medicare-eligible. Please contact your Human Resources or Benefits Department if you need information on Group Retiree Benefit Plan options for yourself or your dependents that are not Medicare-eligible.

Special Enrollment/Special Enrollees

If you meet all the eligibility requirements listed in this Certificate, but did not enroll in this Plan because of other health insurance coverage, you may in the future be able to enroll in this Plan provided that you submit a complete application within 31 days after other coverage ends.

In addition, if a Covered Retiree has a new Medicare-eligible Dependent as a result of marriage, adoption, or placement for adoption, the new Dependent may be able to enroll in this Plan, provided that a complete application is submitted within 31 days after the marriage, adoption, or placement for adoption and the Dependent meets all the other eligibility requirements listed in this Certificate.

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

Open Enrollment

Some Group Retiree Benefit Plans offer an annual Open Enrollment period. An Open Enrollment period is a period of time when an eligible Retiree or Dependent who did not request enrollment for coverage during their initial enrollment period or a special enrollment period can apply for coverage.

Please contact your Human Resources or Benefits Department to find out whether your Group Retiree Benefit Plan offers Open Enrollment periods.

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

Notice of Changes

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

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

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

A member's benefits under this Certificate terminate on the last day of the month in which the member ceases to be in a class of members eligible for coverage. The Plan has the right to bill the Covered Retiree for the cost of any services provided to such person during the period such person was not eligible for coverage.

Nondiscrimination

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

Statements and Forms

The eligible Retiree or Dependent must complete and submit their applications for this Plan which is part of the Group Retiree Benefit Plan offering for Retirees and their Dependents that are Medicare-eligible.

Applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a member may result in termination of benefits as provided in the **Changes in Benefits: Termination and Continuation of Benefits** section.

Delivery of Documents

We will provide a Membership Card and Certificate for each enrolled member.

Please carry your Membership Card with you at all times and remember to show your card when you get covered drugs. If your Plan Membership Card is damaged, lost, or stolen, call Customer Service right away and we will send you a new Membership Card.

Changes in Benefits: Termination and Continuation of Benefits

Termination of the Member

The member's enrollment in this Plan shall terminate:

1. The date the Group Contract with us terminates.
2. The date that coverage under the Group Part D Plan which this Plan supplements ends, whether you voluntarily or involuntarily terminate your Group Part D Plan.
3. If the Employer offers an Open Enrollment Period for retiree benefits, the Covered Retiree may voluntarily terminate coverage effective as of the renewal date of the Group Retiree Benefit Plan.
4. The day following the Covered Retiree's death. When a Covered Retiree dies, Dependents shall be terminated the last day of the month in which the Covered Retiree died, unless the Group Retiree Benefit Plan allows dependents to remain enrolled.
5. The last day of the month in which the Covered Retiree or Dependent no longer meets the eligibility requirements of the Retiree Drug Plan as defined in the **Eligibility** section of this Certificate.
6. When a Member ceases to be a Covered Retiree or Dependent, or the required contribution, if any, is not paid, the member's benefits under this Certificate will terminate the last day of the month for which payment was made.
7. Termination of an enrolled Dependent's benefits under this Certificate will occur on the last day of the month in which one of the following events occurs:
   - Divorce or legal separation of the spouse;
   - Other enrolled dependent's criteria are no longer met by the spouse or enrolled Dependents as defined in the **Eligibility** section;
   - Death of an enrolled Dependent.
8. Upon written request through the Employer, a Covered Retiree may cancel the enrollment of any Dependent from the Plan. If this happens, no benefits will be provided for covered services provided after the Dependent's termination date.
9. If the Covered Retiree or Dependent lets someone else use the Membership Card to get prescription drugs.

Consent

No event of termination, expiration, non-renewal, or cancellation of this Retiree Drug Plan shall affect the rights and obligations of the parties arising out of any transactions occurring prior to the Effective Date of any such event. The member hereby acknowledges that the termination, expiration, non-renewal, or cancellation of the contract will automatically result in the termination of this Retiree Drug Plan.

Continuation of Benefits

Federal Continuation of Coverage (COBRA)

If you or your covered Dependent no longer qualify for benefits under this Plan, you or your Dependent may be eligible to continue group coverage under Federal COBRA. Please contact your Human Resources or Benefits Department for information on COBRA prior to benefits under this plan ending.

Grievance Procedures

If you have a question about your eligibility, your benefits under this Plan, or concerning a claim, please call the telephone number listed on your Identification Card, or you may write to the Claims Administrator (please address your correspondence to Anthem, 4361 Irwin Simpson Road, Mason, OH 45040-9498, marked to the attention of the Customer Service Department listed on your Identification Card). The Customer Service staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form from the Customer Service representative. You may complete and return the form to the Claims Administrator, or ask the Customer Service representative to complete the form for you over the telephone. You may also submit a grievance online or print the Plan Grievance Form through the Anthem website at **www.anthem.com/ca**. You must submit your grievance no later than 180 days following the date you receive a denial notice from the Claims Administrator or any other incident or action with which you are dissatisfied. Your issue will then become part of the Claims Administrator's formal grievance process and will be resolved accordingly.

All grievances received by the Claims Administrator will be acknowledged in writing, together with a description of how the Claims Administrator proposes to resolve the grievance. After reviewing your grievance, the Claims Administrator will send you a written statement on its resolution within 30 days. If your case involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

General Provisions

Entire Contract

This Certificate, the Group Contract, Group Application, and the individual applications of the Covered Retiree and Dependents, if any, constitute the entire Contract between you and the Employer and under which Anthem providers claims administration services. Any and all statements made to you by the Employer or Claims Administrator and any and all statements made to the Employer or Claims Administrator by you are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

Form or Content of Certificate

No agent or employee of the Employer or Claims Administrator is authorized to change the form or content of this Certificate. Changes can only be made through a written authorization, signed by an officer of the Employer.

Payment of Benefits

You authorize us to make payments directly to providers for covered services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Covered Retiree who is recognized, under a Qualified Medical Child Support Order (QMCSO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any payments made by us will discharge our obligation to pay for covered services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a provider performs a covered service, we will not honor a request for us to withhold payment of the claims submitted.

Assignment

Benefits available under this Certificate are not assignable by any member without obtaining written permission from the Employer, unless in a way described in this Certificate.

Notice of Claim

Unless your prescription order is submitted to us electronically by the pharmacy, a written notice of a claim must be submitted to us within 90 days of when the Covered Services were provided. Failure to give notice within the time frame will not invalidate nor reduce any claim if it was not reasonably possible to give notice and notice was given as soon as was reasonably possible. All claims must be submitted to us within 12 months of when the Covered Services were provided, except in the absence of legal capacity.

Claim Forms

Claim forms are not required to obtain benefits. If you want a claim form you may either send a written request for claim forms to us or call Customer Service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you prefer not to use a claim form, please send us a written request for payment. Your request should include your name and address, your Plan membership number, your receipt documenting the outpatient drug(s) you received, the payment you have made and the currency conversion rate (if needed). It's a good idea to make a copy of your receipts for your records.

Timely Payment of Claims

Any benefits due under this Plan shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.

Member's Cooperation

Each member shall complete and submit to the Employer or Claims Administrator such authorizations, consents, releases, assignments and other documents as may be requested by the Employer or Claims Administrator in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any oher governmental program.

Any member who fails to cooperate (including a member who fails to enroll under Part B and/or Part D of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits (EOB)

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

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

Worker's Compensation

The benefits under this Certificate are not designed to duplicate benefits that members are provided under the Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to a member shall be paid back by, or on behalf of, the member to the Plan or Claims Administrator, on behalf of the Plan and Employer, if the Plan has made or makes payment for the services received. It is understood that coverage under this Certificate does not replace or affect any Worker's Compensation coverage requirements.

Other Government Programs

The benefits under this Certificate shall not duplicate any benefits that members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If the Plan has duplicated such benefits, all money paid by such programs to members for services they have or are receiving, shall be paid by or on behalf of the member to the Plan.

Right of Recovery

Whenever payment has been made in error, the Claims Administrator, on behalf of the Employer and Plan, will have the right to recover such payment from you or, if applicable, the provider. The Claims Administrator, on behalf of the Employer and Plan, reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Relationship of Parties (Plan-Employer-Member-Claims Administrator)

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

The Employer and plan sponsor or plan administrator are fiduciary agents of the member. The Claims Administrator's notice to the Employer will constitute effective notice to the member. It is the Employer's, plan sponsor's or plan administrator'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, plan sponsor or plan administator fails to provide the Claims Administrator with timely notification of member enrollments or terminations.

Modifications

This Certificate 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 prescription drug 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.

Legal Actions

No attempt to recover on the Plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this Plan. No such action may be started later than three years from the time written proof of loss is required to be furnished.

Conformity with Law

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

Clerical Error

A clerical error will never disturb or affect a member's coverage, as long as the member's coverage is valid under the rules of this Certificate. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or the Claims Administrator.

Reservation of Discretionary Authority

Anthem 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 Certificate. This includes, without limitation, the power to construe the Group Contract, to determine all questions arising under the Plan, to resolve member complaints and appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Certificate. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Certificate. Anthem's determination shall be final and conclusive and may include, without limitation, determination of whether the services or supplies are Medically Necessary, Experimental/Investigative and whether charges are consistent with the Plan's Maximum Allowable Amount. A member may utilize all applicable Grievance procedures.

Definitions

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

If you need additional clarification on any of these definitions, please contact Customer Service at the number located on the back of your Membership Card.

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

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

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

Claims Administrator – An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

Coinsurance – A specific percentage of the Maximum Allowable Amount for covered services that are indicated in the benefit chart, which you must pay.

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

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

Covered Retiree – A retiree of the Employer who is eligible to receive benefits under the Group Contract, who has applied for coverage under this Certificate, and who has been approved for coverage under this Certificate.

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

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

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

Group – The employer or union that has entered into a contract with the Claims Administrator to provide claims administration services for the Plan.

Group Contract (Group Policy, Contract) – The Contract between the Claims Administrator and the Employer under which the Claims Administrator provides claims administration services for the Plan. It includes the Group Contract, Group Application, this Certificate and your Application.

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

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

Medical Emergency Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

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

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

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

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

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

Definitions continued

Member – A Covered Retiree or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required premium payment. Members are sometimes called "you" or "your" in this Certificate.

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

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

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

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

Pharmacy Benefits Manager (PBM) – The entity with which the Plan has contracted with to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with the Plan.

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

Premium – The charges that must be paid by the Covered Retiree or the Group to maintain coverage.

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

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Prescription drugs and their criteria for coverage are defined by the P&T Committee.

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

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

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

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

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


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