

Applies to:

Non Bargained, CSSNA, DRC-IAM, DWU LDD, BB & CMEP,  
OCU and UAW



**Cummins Inc. U.S. Group Medical PPO Plan  
and Summary Plan Description**

**Plan Document and Summary Plan Description effective January 1, 2022**

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## **Dictionary Terms**

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The following terms are used throughout the Plan as having special meaning. In this section, you will find the definitions for these terms to help clarify their meaning and to provide information to better help you understand the provisions of the Plan. These words are capitalized throughout this document to indicate that these special meanings are in place.

### **Actively at Work**

Present and capable of carrying out the normal assigned job duties at the Company. If you are absent from work due to an approved health-related Short-Term Disability Leave, FMLA leave or regularly scheduled vacation, you will be considered Actively at Work. If you are not Actively at Work due to a health status-related factor, as defined in HIPAA, you will still be treated as if you were Actively at Work.

### **Base Salary**

The earnings term the Company uses in determining a Covered Employee's eligibility for an increased Company contribution to their Health Savings Account (HSA). Base Salary is a Covered Employee's regular or base salary. It does not include other types of pay, including but not limited to team pay, shift differential, overtime, bonuses, incentive pay, relocation expense payments, car expense payments or tuition reimbursements.

### **Brand-Name Drug**

A drug that is protected by a patent issued to the original Company that invented or marketed the drug.

### **Business Associate**

A person who provides the Plan with services that involve the use or disclosure of Protected Health Information. An Employee of the Company or other workforce member under the control of the Company is not considered a Business Associate of the Plan.

### **Certificate of Creditable Coverage**

Documentation confirming your last 18 months of health coverage that can help you get coverage without a Pre-Existing Condition exclusion.

### **Claims Administrator**

The person or firm employed by the Company who is given authority by the Company to provide administrative services, including determining the medical, Prescription Drug, and vision benefits payable under the Plan. The Claims Administrators of the Plan are listed in the **GENERAL INFORMATION ABOUT THE PLAN** section.

## **COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, which is the federal law that lets certain people covered by a group health plan temporarily extend coverage when their coverage would otherwise end by paying the applicable premium.

## **Coinsurance**

A percentage of expenses that you are responsible for paying after you meet your Deductible.

## **Common-Law Spouse**

A person you marry without a civil or ecclesiastical ceremony, in accordance with applicable state law. This is based on your living together continuously as husband and wife for an extended period of time. Time limits vary by state.

## **Company**

The association or organization for which you work and that provides your benefits under the Plan. This includes Cummins Inc. and its affiliates and subsidiaries. A complete list of the employers participating in the Plan may be obtained upon written request to the Plan Administrator, as well as information regarding whether your employer is a sponsor of the Plan.

## **Copay**

The flat dollar amount you pay for a certain types of Covered Services.

## **Covered Employee**

An Employee who has met the eligibility requirements of, and is covered under, the Plan.

## **Covered Expenses**

Expenses incurred by a Member for Covered Services.

## **Covered Services**

Medically Necessary services, supplies or treatment as described in the Plan that are performed, prescribed, directed, or authorized by a Provider. To be considered Covered Services, services must be:

- within the scope of the license of the Provider performing the service;
- rendered while benefits under the Plan are payable;
- a Reasonable Charge;
- not specifically excluded by the Plan; and
- not in excess of the limits specified in the Plan.

A Covered Service is incurred on the date the service, supply, or treatment was provided and not when you are formally billed, charged for, or pay for the service, supply, or treatment.

### **Custodial Care**

Care primarily for the purpose of assisting in the activities of daily living or in meeting personal rather than medical needs. Care that cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Custodial Care is not specific treatment for an illness or injury and is not covered under the Plan.

Such care includes, but is not limited to:

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

### **Deductible**

The amount of Covered Expenses you are responsible for paying each Plan Year before the Plan starts paying certain benefits.

### **Dependent**

Your legal Spouse, Common-Law Spouse, Domestic Partner, or child who is eligible for coverage under the Plan as described in the **ELIGIBILITY** section.

### **Diagnostic Service**

A test or procedure performed when you have specific symptoms to detect or to monitor a certain disease or condition.

### **Disability**

A condition that causes you to be unable to perform one or more regular job duties.

## **Domestic Partner**

Someone of the opposite sex or same sex under the following criteria:

- you and your Domestic Partner have had a single, dedicated relationship with each other and have shared the same living quarters and permanent residence for at least six months;
- your Domestic Partner is not married to another person or part of another Domestic Partner relationship and is 18 years of age or older;
- you and your Domestic Partner are mutually responsible for each other's common welfare;
- you and your Domestic Partner intend for your relationship to be permanent; and
- you and your Domestic Partner are not related to one another so closely as to preclude marriage under applicable state law.

To apply for coverage for your Domestic Partner, complete an Affirmation of Domestic Partnership and send it to the CBS Benefits Contact Center (see the **CONTACTS** section for more information).

## **Effective Date**

The date your coverage begins under the Plan as set forth in the **ENROLLMENT** section.

## **Emergency and Emergency Care**

A medical condition (and the medical care for it) that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

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

## **Employee**

A person the Company hires to do a job or activities that are controlled by the Company.

## **ERISA**

The Employee Retirement Income Security Act of 1974, as amended.

## **Exempt**

Employees who receive fixed compensation paid regularly for work or services, regardless of the number of hours worked each week, who are "exempt" from overtime.

## **Experimental/Investigational**

A drug, device, supply, procedure or treatment that the Claims Administrator or Claims Administrator's designee determines (at his/her sole discretion) at the time of treatment or use if:

- there is insufficient outcome data available from controlled clinical trials published in the peer review literature to substantiate its safety and effectiveness for the disease or injury involved;
- if required by the U.S. Food and Drug Administration (FDA), approval has not been granted for marketing;
- a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
- the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

Documents the Claims Administrator relies upon to determine whether Covered Services are Experimental/Investigational based on the criteria in the above sections may, at the Claims Administrator's discretion, include one or more items from the following list, which is not all inclusive:

- the Member's medical records;
- the written protocol(s) or other document(s) pursuant to which the Covered Service has been or will be provided;
- the published, authoritative, peer-reviewed medical or scientific literature regarding the Covered Service as it applies to the Member's condition;
- any consent document(s) the Member or Member's representative has executed or will be asked to execute to receive the Covered Service;
- the relevant documents of the Institutional Review Board or similar body that approves or reviews research at the institution where the Covered Service has been or will be provided;
- any records, regulations, applications or other documents or actions issued by, filed with, or received by the FDA, the Office of Technology Assessment, or other federal or state agencies with similar functions, that the Claims Administrator or the Claims Administrator's designee, has in its possession at the time of the review; and
- opinions and evaluations by national medical associations or committees, consensus panels, or other technology evaluation bodies, such as the Claims Administrator's Technology Evaluation Center.

## **Family and Medical Leave Act (FMLA)**

The Family and Medical Leave Act of 1993, as amended, which is a Federal law that provides for various types of family and medical leave, such as:

- leave for an Employee's serious health condition or the serious health condition of the Employee's Spouse, child, or parent,
- leave for the birth, adoption or foster care placement of a child, or
- leave because of any qualifying exigency arising out of the fact that the Spouse, son, daughter, or parent of the Employee is on duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

## **Family Coverage**

Enrollment in Plan coverage for yourself and any other eligible Dependent(s) (*i.e.*, Employee plus Spouse, Employee plus child, or Employee plus Family Coverage).

## **Family Deductible**

The amount of Covered Expenses you and your eligible Dependents are responsible for paying each Plan Year before the Plan starts paying certain benefits.

## **Formulary**

A listing of Prescription Drugs that includes brand and generic equivalents which may be periodically amended, that Providers should use in prescribing Prescription Drugs. Drugs placed on the Formulary are chosen by a Pharmacy & Therapeutics (P&T) Committee. When a drug is considered for the Formulary, inclusion of the drug is typically examined relative to similar drugs on the Formulary. Entire therapeutic classes are periodically reviewed. This review may result in tier status changes or exclusions of drugs in a particular therapeutic class in an effort to continually promote the most clinically useful and cost effective agents. Drugs evaluated by the P&T Committee may not be added to the Formulary or excluded due to belief that the drug offers no known clinical or cost advantage over comparable Formulary drugs, or there is currently insufficient scientific information to determine the drug's appropriate clinical role. Excluded drugs from the Formulary will require full cost share of the drug without reimbursement under the plan for the participant. A Formulary exception review for medical necessity may be initiated by the Provider in order to determine if an excluded drug would be covered by the plan for a particular participant.

## **Generic Drug**

A drug that generally contains the same ingredients and has the same effect as a Brand-Name Drug, but is manufactured by a company other than the one that manufactures the Brand-Name Drug.

## **HIPAA**

The Health Insurance Portability and Accountability Act of 1996, as amended.



## **Home Health Care**

Services provided as needed in a patient's home by a Home Health Care Agency or by others under arrangements made by a Home Health Care Agency.

## **Hospice Care**

Home care or Inpatient care for a patient with a terminal illness.

## **Hospital**

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

- provides room and board and nursing care for its patients;
- has a staff with one or more Physicians available at all times;
- provides 24 hour nursing service;
- maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
- is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

- nursing care;
- rest care;
- convalescent care;
- care of the aged;
- custodial care;
- educational care;
- treatment of alcohol abuse; or
- treatment of drug abuse.

## **Identification Card**

A card the Plan sends you that contains information your Provider needs to process your medical expenses.

## **Individual Coverage**

Enrollment in Plan coverage for you only.

## **Individual Deductible**

The amount of Covered Expenses each Member is responsible for meeting each year before the Plan starts paying certain benefits.

## **In-Network Provider**

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

## **Inpatient**

When you are admitted to the Hospital and stay more than 24 hours.

## **Mail Order Service**

A Prescription Drug program that offers you a convenient means of obtaining maintenance medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Order Service that has entered into a reimbursement agreement with the Company, and sent directly to your home.

## **Medically Necessary or Medical Necessity**

Services or supplies received for the treatment of an illness or injury or other health condition or that is medically appropriate for the patient's age or sex as a preventive measure for an asymptomatic patient that is determined by the Claims Administrator to be:

- appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards;
- not chiefly Custodial in nature;
- not Experimental/Investigative;
- not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment and as to institutional care, cannot be provided in any other setting, such as a Physician's office or the Outpatient department of a Hospital, without adversely affecting the patient's condition; or
- not provided only as a convenience to the patient, the patient's Physician, or another Provider or person.

The fact that any particular Provider may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary.

Any service or supply provided at a Provider Facility will not be considered Medically Necessary if the Member's symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

The Claims Administrator is responsible for making the determination as to whether services or supplies are Medically Necessary.

## **Medicare**

The U.S. federal government's plan administered by the Social Security Administration, that pays certain Hospital and medical expenses for those who qualify, primarily those over 65 or totally and permanently disabled. It is the program established by Title I of Public Law 89-97 (79 Statutes 291), as amended, and entitled Health Insurance for the Aged Act, which includes Part A - Hospital Benefits for the Aged, Part B - Supplemental Medical Insurance Benefits for the Aged, Part C - Medicare Advantage, and Part D – Voluntary Prescription Drug Benefit Program.

## **Member**

You and your Dependent(s) who have satisfied the eligibility conditions, applied for coverage under the Plan, and been approved by the Company.

## **Mental Health Conditions (including Substance Abuse)**

A condition identified as a mental disorder in the most current version of the International Classification of Diseases, in the Chapter entitled "mental disorders" as follows:

- mental health is a condition that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical cause; and
- substance abuse is a condition brought about when an individual uses alcohol or other drugs in such a manner that his or her health is impaired and/or ability to control actions is lost.

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

## **New FDA Approved Drug Product or Technology**

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

New FDA Approved Drug Product or Technology does not include:

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

## **Non-Exempt**

Employees entitled to overtime pay under the Fair Labor Standards Act of at least one and one-half times regular hourly earnings for all hours worked over 40 hours in a week.

## **Non-Participating Transplant Facility**

A Hospital, which has not contracted with the Claims Administrator to provide covered transplant procedures. Benefits are paid at a reduced rate when a Non-Participating Transplant Facility is used.

## **Out-of-Network Provider**

A Provider who is not an In-Network Provider. These providers are not members of the insurance company's preferred network of providers. Costs are typically higher to see an Out-of-Network Provider.

## **Out-of-Pocket Maximum**

The maximum amount you or your eligible Dependents have to pay toward the cost of covered medical care in the course of one year. There are some exceptions to the Out-of-Pocket Maximum. See the **COST-SHARING PROVISIONS** section for more information.

## **Outpatient**

When you receive health care without being admitted as an overnight patient for less than 24 hours.

## **Participating Transplant Facility**

A Hospital that has contracted with the Claims Administrator to provide covered transplant procedures. Benefits are paid at a higher rate when a Participating Transplant Facility is used.

## **Plan**

The group benefits Plan and Summary Plan Description (SPD) provided by the Company as set forth in this document and as amended from time to time known as the "Cummins Inc. U.S. Group Medical Plan and Summary Plan Description." This document serves as both the official plan document and Summary Plan Description.

## **Plan Administrator**

The Plan Administrator administers the Plan and is a named fiduciary of the Plan within the meaning of ERISA. The Plan Administrator has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits. The Company is the Plan Administrator. As used in this Plan, the term Plan Administrator shall also refer to any person or entity designated by the Plan Administrator to perform a function under the Plan.

## **Plan Year**

The 12-month period, or policy or fiscal year on which the Plan's records are kept. The Plan Year is January 1 through December 31.

## **Precertification**

Prior authorization a Member may need to receive full benefits.

## **Premium**

The amount of money you pay each month for benefit coverage. Your premium may be taken from your paycheck on a "pre-tax" basis before applicable federal, state, local and other taxes are withheld.

## **Prescription Drugs**

A medical drug approved by the FDA as safe and effective and that is only available when prescribed by a licensed Physician and legally dispensed by a licensed pharmacist and bears the following warning: "Caution: Federal Law prohibits dispensing without a prescription."

## **Prescription Drug Identification Card**

A card the Plan sends you that contains information your pharmacy needs to process your prescription drug expenses. This information is included on your Anthem Medical Plan ID card.

## **Preventive Prescription Drugs**

Drugs or medications when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (*i.e.*, asymptomatic), or to prevent the reoccurrence of a disease from which a person has recovered. Drugs or medications used as part of procedures providing preventive care services specified in IRS Notice 2004-23, including obesity weight-loss and tobacco cessation programs, are also Preventive Prescription Drugs.

## **Protected Health Information**

Health Information (including demographic information) that:

- identifies an individual (or provides a reasonable basis to believe the information can be used to identify an individual);
- is created or received by a health care Provider, a health plan, or certain other entities of the health care industry;
- relates to the past, present, or future physical or mental health or condition of an individual; information regarding health care provided to an individual; or the past, present, or future payment for an individual's health care; and
- is transmitted in any form or medium.

Protected Health Information does not include employment records held by the Company or records related to other employee benefits provided by the Company.

Electronic Protected Health Information is Protected Health Information that is transmitted or maintained by or in electronic media (such as e-mails). For purposes of this Plan, the term "Protected Health Information" will refer to both Protected Health Information and electronic Protected Health Information, unless otherwise noted.

## **Provider**

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

- Alcoholism Treatment Facility (a facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism);
- Ambulatory Surgical Facility;
- Certified Nurse Midwife;
- Certified Registered Nurse Anesthetist (C.R.N.A.);
- Diabetic Education;
- Dialysis Facility;
- Drug Abuse Treatment Facility;
- Home Health Care Agency;
- Home Infusion Facility;
- Hospice;
- Hospital;
- Laboratory (Clinical);
- Licensed Practical Nurse (L.P.N.);
- Occupational Therapist;
- Ophthalmologist;
- Optician;
- Optometrist;
- Outpatient Psychiatric Facility;
- Pharmacy;
- Physical Therapist;
- Physician that holds a professional license under applicable State law as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Podiatrist or Surgical

Chiropodist (D.P.M. or D.S.C.), Dental Surgeon (D.D.S.), Chiropractor (D.C.), or Doctor of Optometry (O.D.);

- Psychiatric Hospital;
- Psychologist;
- Rehabilitation Hospital;
- Respiratory Therapist;
- Registered Nurse;
- Registered Nurse Practitioner;
- Registered Physician's Assistant;
- Skilled Nursing Facility;
- Social Worker;
- Speech Therapist;
- Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Medical Supplies; and
- Urgent Care Center.

### **Qualified Medical Child Support Order (QMCSO)**

A judgment, decree, or order that is issued by a court of competent jurisdiction or through an administrative process established under State law that has the force and effect of law under applicable state law, that is determined by the Plan Administrator or its designee to meet the requirements of Section 609 of ERISA, and that meets all of the following criteria:

- provides for child support with respect to a child of a Member under the Plan or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under the Plan; or
- is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act with respect to the Plan.

### **Qualifying Event**

An event recognized by Section 125 of the Internal Revenue Code that permits you to make a change in election. Examples of events include leaving the Company; a reduction in hours; marriage; birth of your child; your death, divorce or legal separation; your eligibility for Medicare; a Dependent child's loss of Dependent status; or loss of coverage due to your filing for bankruptcy.

### **Reasonable Charge**

The maximum amount that the Claims Administrator determines is reasonable for Covered Services you or your eligible Dependents receive, up to but not to exceed

charges actually billed. The Claims Administrator's determination is based on the amount accepted by an In-Network Provider as payment in full under this Plan. The Claims Administrator's determination considers the contracted rate for services in a geographic area. The Reasonable Charge is reduced by any penalties for which a Provider is responsible as a result of its agreement with the Claims Administrator.

### **Recovery**

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

### **Rescission**

Rescission is cancellation or discontinuance of coverage that has a retroactive effect, e.g. coverage declared void from the time of enrollment. It is not considered a rescission if termination of coverage has a prospective effect or is retroactive due to failure to timely pay premiums or contributions.

### **Service in the Uniformed Services**

A term meaning: (a) the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active and inactive duty for training, National Guard duty under Federal law, (b) a period for which a Covered Employee is absent from a position of employment for the purpose of an examination to determine the fitness of the Covered Employee to perform any such duty, (c) a period for which a Covered Employee is absent from employment to perform funeral honors duty as authorized by law, and (d) service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System or as a participant in an authorized training program.

### **Short-Term Disability Leave**

A leave of absence granted by the Company to a Covered Employee under the Cummins Inc. Short Term Disability Policy, as it may be amended from time to time.

### **Skilled Nursing Facility**

An institution that provides skilled nursing care (or convalescent care) after or instead of Hospital confinement.

### **Spouse**

Your lawful husband or wife, determined under the laws of the State where you reside.



## **Telehealth (Telemed) Services**

Consultations with your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet)

## **Therapy Services**

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

## **Uniformed Services**

The Armed Forces; the Army National Guard and Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commission corps of the Public Health Service; and any other category of persons designated by the President of the United States of America in time of war or emergency. For purposes of USERRA coverage only, services as an intermittent disaster response appointee of the NDMS when federally activated or attending authorized training in support of their Federal mission is deemed Service in the Uniformed Services, although such appointee is not a member of the "uniformed services" as defined by USERRA.

## **Urgent and Urgent Care**

An unexpected episode of illness or an injury requiring treatment, which cannot reasonably be postponed for regularly scheduled care, and the medical care for that illness or injury.

## **USERRA**

The "Uniformed Services Employment and Reemployment Rights Act of 1994," as amended.

## **Preface**

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This booklet is the Cummins Inc. U.S. Group Medical PPO Plan and Summary Plan Description ("Plan"). This Plan document provides a concise description of medical coverage available to you and your eligible Dependents. Every attempt has been made to make it non-technical and understandable. This document is the "summary plan description" (SPD) of the Plan required by the federal law known as ERISA. It is also the official Plan document. This Plan supersedes any previous plan documents and any provision or practice not consistent with this Plan.

Groups covered by this Summary Plan Description

Non Bargained employees of Cummins Inc., bargained and non-bargained employees of Cummins Sales and Service North America organization, and Cummins Inc. employees represented by the following unions: DWU Base Business, DWU CMEP, DWU LDD, UAW and OCU.

The Company reserves the right to suspend, modify, or terminate these benefits at any time to the extent permitted by law. This Plan document does not constitute a contract of employment or a guarantee of any particular benefit.

If you have questions about whether this Plan applies to you, please contact the CBS Benefits Contact Center toll free at (877) 377-4357 (see the **CONTACTS** section).

## **Introduction**

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The Company gives you the option to choose a medical plan that works best for you and your eligible Dependents.

Here's how the Plan works:

- For office visits and routine exams, you usually pay a set dollar amount called a "copay" each time you receive care from in-network providers.
- For most covered medical services and supplies, you must first pay a deductible.
- If your eligible expenses exceed your Deductible, then Coinsurance begins. Coinsurance is where a portion of expenses are paid by you and a portion of expenses are paid by the Plan.
- Medical expenses that meet the Plan's definition of "preventive care," as described below, are not subject to the Deductible and do not apply toward your Deductible. The Plan pays 100% of these expenses.
- Expenses for Prescription Drugs are not subject to the Plan's Deductible and do not apply toward your Deductible. You pay Copays for Prescription Drugs. Prescription Drugs do count toward your out of pocket limit. .
- For your added protection, the total amount you spend annually out of your pocket is limited. Once you spend the Out-of-Pocket Maximum, the Plan pays 100% of the cost for certain Covered Services, including Prescription Drugs, for the remainder of the Plan Year. Your annual Out-of-Pocket Maximum consists of amounts you spend to satisfy the Deductible and your portion of Coinsurance, and Prescription Drugs.

## **Eligibility**

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### **Eligible Employees**

This Plan applies to active Employees who are scheduled to work for the Company twenty or more hours per week, or who are on an approved leave of absence.

## Eligible Dependents

You can cover certain Dependents under the Plan. Your eligible Dependents are any of the following:

- a Common-Law Spouse, if recognized by the State of residence;
- a legal Spouse;
- a Domestic Partner;
- a child under age 26; and
- an unmarried, Dependent child over age 26 if permanently and totally disabled (as defined below).

Dependent children include:

- a natural child of the Employee, Employee's Spouse, or Domestic Partner;
- a legally adopted child of the Employee, Employee's Spouse, or Domestic Partner;
- a child for whom the Employee, Employee's Spouse, or Domestic Partner is the legal guardian (including a grandchild or foster child);
- a child placed for adoption, before the adoption is final;
- a child who the court has issued a QMCSO;
- a stepchild who is living with the Employee;
- a dependent of the Employee's Domestic Partner; or
- a Dependent recognized as a dependent by the IRS.

Note that although the Plan extends coverage to the children of a Domestic Partner, because such children would not be the legal stepchildren of the Employee, and would therefore have no legal relation to the Employee, premiums for coverage must be paid on an after-tax basis. Further, in other instances (such as most Domestic Partners), an eligible Dependent may not qualify as your dependent under the Internal Revenue Code, and benefit coverage for that Dependent may not be entitled to the same favorable tax treatment as provided to a Spouse or for a Dependent that is your dependent under the Internal Revenue Code. You should consult with your tax advisor for further details on the tax implications of this coverage.

A newborn child is eligible for coverage from birth if enrolled within 60 days of birth.

In the case of an adoption, a child becomes eligible for coverage when the child is placed in your home.

A child shall be considered to be "permanently and totally disabled" if such child is unable to engage in any substantial gainful activity by reason of a medically-determinable physical or mental impairment which can be expected to result in death, or has lasted or can be expected to last for a continuous period of not less than 12 months. A disabled Dependent must be an unmarried child who is or has become permanently and totally disabled prior to age 26 and who is incapable of self-sustaining

employment and is chiefly dependent upon you for support and maintenance (this means your child must live with you for more than ½ the year and provide not more than ½ of his or her own support during the year). If the disabled Dependent child was eligible to be covered under the Plan prior to age 26, they must be enrolled in the Plan on their 26<sup>th</sup> birthday in order to continue coverage after the limiting age. Within 120 days prior to the Dependent's 26<sup>th</sup> birthday, you must initiate disabled status certification with the Claims Administrator. If the Dependent's first eligibility for Plan coverage occurs after age 26 due to the parent being a new hire or the parent acquiring the Dependent due to marriage, an over age 26 disabled Dependent can only be enrolled during the initial 31-day enrollment period of their parent. A disabled Dependent must be enrolled prior to age 26 or within 31 days of their initial eligibility for coverage. You must re-certify a Dependent's disabled status if required to do so by the Claims Administrator or the Plan Administrator in order to continue coverage. If the disabled Dependent fails to be timely enrolled or there is a break in coverage, a disabled Dependent will no longer be eligible for coverage. A disabled Dependent over age 26 can not be enrolled during open enrollment.

If your Spouse/Domestic Partner is employed by the Company and is enrolled for Employee coverage under this Plan, you may not cover that person as a Dependent. In addition, only one of you may cover your Dependent children. You both cannot cover your child at the same time.

You must notify the Company if you experience a change that will affect your Dependent's eligibility for benefits under the Plan within 31 days of the event date.

### **Eligibility Ends**

Your eligibility and your Dependents' eligibility to participate in this Plan ends when:

- your employment at the Company ends;
- you are no longer working in a benefits-eligible position;
- you or your Dependent provide false information on enrollment forms, coordination of benefit forms, or claims;
- you fail to make your required contribution to the Plan;
- the Plan ends or the applicable portion of the Plan ends; or
- you are no longer receiving compensation through a disability plan or leave policy or you no longer qualify for health care coverage through the provisions of a disability plan or leave policy. For example, coverage will last no longer than 24 months after the effective date of your disability under the Cummins Inc. Long-Term Disability Policy.

In addition, a Member's coverage will end when the Member becomes a full-time member of the armed forces of any country; however continuation coverage may be available as set forth in the **USERRA RIGHTS AND COVERAGE** section of this Plan.

Finally, with respect to a Dependent, the Dependent shall lose coverage the date the Dependent: (a) ceases to be classified as a Dependent (which for a Domestic Partner

shall be when the relationship ends or any criteria for eligibility benefits are not met); or (b) dies.

For information regarding rights you and your Dependents may each have to continue your health care benefits, refer to the **COBRA** section of this Plan.

If you die while covered, group health benefits for your covered Dependents may be continued for up to 6 months after your death at the premium normally charged to active employees. Your covered Dependents must make the required premium payments during that period of time. If your Spouse remarries before the end of the 6 months, the health coverage for your covered Dependents will end when your Spouse remarries. Any coverage provided to your covered Dependents will run concurrently with any COBRA coverage available to your covered Dependents as a result of your death.

**The plan reserves the right to rescind coverage in the event of fraud or intentional misrepresentation of a material fact. The participant will be given at least 30 days advance written notice before the coverage is rescinded. It is not rescission if coverage is termed retroactively due to failure to pay required premiums or contributions.**

### **Changes in Status**

Each Member is required to notify the Plan Administrator of any Qualifying Event. In addition, the Plan Administrator shall be notified as soon as possible of: (a) a change in address; (b) entrance into the military by the Member; (c) eligibility for and/or entitlement to Medicare; (d) an individual ceasing to be a Dependent under the terms of the Plan; or (e) any other change in status or other applicable event which might affect a Member's coverage under the Plan. Moreover, in the event of a change in circumstances which makes any part of the Affirmation of Domestic Partnership and Healthcare enrollment form inaccurate, you must notify the Plan Administrator within 31 days after a change in status.

A Member is responsible for notifying the Plan Administrator of any change in status or other applicable event, or the Member may be liable for the costs, fees, and expenses incurred by the Company for failure to notify. The Plan Administrator or the Claims Administrator may request whatever documentation it deems necessary to substantiate a claimed change in status or other applicable event.

## **Enrollment**

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### **Enrolling in the Plan**

If you are a newly hired Employee, you have 31 days from your date of hire to enroll in Plan coverage for you and your Dependents. If you do not enroll within this timeframe, you will not be covered under the Plan. You will not have an opportunity to enroll in the Plan until the next open enrollment period. Refer to the **CHANGES IN OPEN ENROLLMENT PERIOD** section below for more information.

If you have a qualified change in family status or other cause for a change in election and become eligible for coverage during the Plan Year, you will have 31 days from the

date of the event to make changes to your coverage. Refer to the **CHANGES IN ELECTION** section for more information.

### **When Coverage Begins**

If you enroll in Plan coverage within 31 days, you and your eligible Dependents' coverage will become effective on your employment date.

If you have a qualified change in family status or other cause for a change in election and become eligible for coverage during the Plan Year, your coverage will start the date of the status/life event as long as you enroll in the Plan within 31 days after the event.

If you are not Actively at Work on the date coverage is to begin, you and your eligible Dependents' coverage will start when you are Actively at Work. If you are not Actively at Work due to a health status-related factor, as defined in HIPAA, you will still be treated as if you were Actively at Work for purposes of determining when your coverage begins.

### **Making Changes**

You may enroll, waive or change your level of coverage (e.g., from Employee only to Employee plus Spouse due to your marriage) during the year if you have a qualified change in family status; otherwise, you may only make changes during open enrollment. Note that you may change plans (e.g., from HSA 1500 to HSA 3000) only at open enrollment.

### **Changes in Election**

If you have a qualified change in family status, you can change your existing Plan coverage level. Any change in election due to a qualified change in family status must be consistent with the qualified change in family status. You must make changes to your coverage within 31 days of your qualified change in family status (60 days for Birth or Adoption events). The following is a list of events that are considered to be a "qualified change in family status:"

- a change in employment status for your Spouse/Domestic Partner that affects your eligibility for benefits;
- a change in the benefit plan available to your Spouse or Domestic Partner;
- birth, adoption, or the placement of a child for adoption with you and your Spouse or Domestic Partner;
- death of your Spouse or Domestic Partner or covered Dependent child;
- divorce, annulment or legal separation from your Spouse;
- issuance of a court order or legal decree requiring coverage of a Dependent child/Domestic Partner's child;
- termination of your Spouse's or Domestic Partner's employment,
- marriage or acquisition of a new Domestic Partner; or

- termination of Domestic Partnership.

**If you become eligible for premium assistance under Medicaid or CHIP programs, or lose eligibility for coverage under Medicaid or CHIP programs, you have 60 days to enroll under this plan (if eligible).**

You may also make changes to your Plan coverage to the extent that the Company's Cafeteria Plan would allow for a change of election under the Cafeteria Plan.

Generally, changes you make after a qualified change in family status become effective the date of the status/life event.

If your Domestic Partnership ends you will not be eligible to cover a new Domestic Partner for another six months. The six-month limitation applies to your Domestic Partner if he/she also works for the Company.

If you are a Member or if you were eligible for the Plan but had previously waived coverage for any reason, and you acquire a new Dependent through marriage, Domestic Partner arrangement, birth, adoption or placement for adoption, or legal guardianship, becoming a foster parent, or becoming a stepparent, you may enroll as a Member any of the following individuals: (a) yourself; (b) the new Dependent child; (c) any existing Dependent children; and/or (d) your Spouse or the Domestic Partner.

If you are otherwise eligible for coverage under this Plan, you may enroll as a Member, and a Dependent of an Employee eligible for the Plan who is otherwise eligible for coverage under this Plan may be enrolled by you as a Member, if the following requirements are met:

- you previously declined coverage under this Plan for yourself or your Dependents because either you or your Dependents had coverage under another group health plan or other health insurance;
- you and/or your Dependents actually had other health coverage at the time coverage under this Plan was declined;
- the other health coverage is lost due to "exhaustion of the COBRA continuation period," "loss of eligibility" under the other coverage, or cessation of company contributions to the other coverage, as those terms are defined below.

In order for changes under this section to be effective, you must (a) contact the Plan Administrator; (b) certify the date the Dependent was acquired; (c) agree to make the required Premiums; and (d) make this election within 31 days after the date of acquiring a new Dependent, or after the loss of other coverage due to "exhaustion of the COBRA continuation period," "loss of eligibility," or cessation of Company contributions, as applicable. You may not enroll a Dependent under this subsection if you are not already a Member or if you are not enrolling yourself at the same time.

For purposes of this section, "exhaustion of a COBRA continuation period" means that an individual's COBRA continuation period ceases for any reason other than either failure of the individual to pay premiums on a timely basis or for cause. For purposes of this subsection, "loss of eligibility" includes a loss of coverage as a result of legal separation, divorce, cessation of dependent status (due, for example, to reaching the maximum age for child coverage), death, termination of employment (other than for

cause), reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. "Loss of eligibility" also includes

being a member of a class for which the Plan no longer offers coverage. "Loss of eligibility" does not occur if the individual failed to pay premiums on a timely basis or if coverage was terminated for cause.

### **Changes During Open Enrollment**

You may change your Plan coverage once a year during open enrollment, except as provided in the **CHANGES IN ELECTION** section.

During the open enrollment period, you may do any of the following:

- drop your coverage;
- elect coverage if previously waived;
- change the level of your coverage, e.g., from Employee to Employee plus family, Employee plus Spouse/Domestic Partner, or Employee plus child(ren)/Domestic Partner child(ren); or
- change from your current Plan to an optional plan available.

All changes in coverage made during open enrollment will become effective on the first day of the new Plan Year.

### **Other Enrollment and Election Issues**

- Dependents shall be covered simultaneously with you. A newborn Dependent must be separately enrolled in order to be covered retroactively from the moment of birth.
- If you cease to be eligible for coverage pursuant to the provisions of the Plan, but your employment with the Company continues, and you later become eligible for coverage again, you shall be allowed to reenter the Plan immediately if you elect coverage again within 31 days after you become eligible for coverage again.
- If you terminate employment with the Company and then return to employment with the Company as an Employee, you shall be allowed to reenter the Plan immediately if you elect coverage again within 31 days after you are rehired and you are in a benefits eligible position. If you change your employment status from Covered Employee to Dependent or Dependent to Covered Employee and you are continuously covered under the Plan before, during, and after the change, credit will be given for Deductibles and all amounts applied to maximums.
- If you are married to another Employee, each Employee can be covered as an Employee or one Employee can cover the other Employee as a Dependent.
- If you have a Domestic Partner relationship with a Domestic Partner who is also an Employee, each Employee can be covered as an Employee or one Employee can cover the other Employee as a Dependent.



- A Dependent may only be covered by one Employee.
- If 2 Employees are married and covered under the Plan and the Covered Employee who is covering the Dependent Child terminates coverage, the Dependent coverage may be continued by the other Covered Employee with no waiting periods or eligibility criteria as long as coverage has been continuous.

### **Family and Medical Leave Act**

The Plan provides continuation coverage consistent with the provisions of the Family and Medical Leave Act of 1993, as amended ("FMLA").

The FMLA generally allows certain Employees the right to take an unpaid leave or a paid leave (if it has been earned under Company's policy) for a period of up to 12 work weeks in a rolling 12 month period because of: (a) the birth of a Child and to care for such Child, (b) the placement of a Child for adoption or foster care, and to care for such Child, (c) the need to care for a family member (child, Spouse, or parent) with a "serious health condition" as defined under the FMLA, (d) because of an Employee's own "serious health condition" which makes the Employee unable to do his or her job; or (e) any qualifying exigency arising out of the fact that the Spouse, son, daughter, or parent of the Employee is on duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

Notwithstanding any other provisions in the Plan to the contrary, under the FMLA a Covered Employee is entitled to continue health care coverage under the Plan during the period the Covered Employee is on a FMLA leave, provided the Covered Employee continues to pay the required contributions. The health care coverage provided pursuant to the FMLA under the Plan is the same as would be provided if the Covered Employee had been employed during the leave period. The Covered Employee may choose not to continue health care coverage under the Plan during the FMLA leave, in which case the Covered Employee shall be immediately reinstated to health care coverage under the Plan when the Covered Employee returns from the FMLA leave and re-enrolls in the Plan within 31 days of the Employee's return.

FMLA health care benefit coverage shall terminate when:

- the Covered Employee informs the Company of his or her intent not to return from FMLA leave;
- the Covered Employee fails to return from the FMLA leave; or
- the Covered Employee exhausts his or her FMLA leave.

Covered Employees on FMLA leave are required to continue to pay required Premiums toward coverage during the FMLA leave. If the FMLA leave is substituted by paid leave, Premiums may be made by payroll deduction under the Cummins Inc. Cafeteria Plan. If the FMLA leave is unpaid leave, Premiums may be made at the same time as the Premium would be made by payroll deduction. Failure of a Covered Employee to pay his or her share of Premiums within 30 days after the due date shall result in termination of coverage, provided the Company has given the Covered Employee 15 days advance written notice of the termination of coverage. If coverage ends due to the failure to make timely Premiums, the Covered Employee shall be entitled to immediate

reinstatement of health care coverage under the Plan on the Covered Employee's return from the FMLA leave as long as the Employee re-enrolls in the Plan within 31 days of the Employee's return. Any changes by the Company to Covered Employee Premiums shall apply while the Covered Employee is on FMLA leave.

The Company may recover from the Covered Employee its share of Premiums paid by the Company during a period of unpaid FMLA leave in order to maintain the Covered Employee's coverage, if the Covered Employee fails to return from work after a FMLA leave has been exhausted, unless the failure to return to work is due to a serious health condition of the Covered Employee or a family member or other circumstances beyond the Covered Employee's control. In addition, the Company may recover from the Covered Employee the Employee's share of the Premiums which the Company paid on the Covered Employee's behalf to maintain coverage, regardless of whether the Employee returns from FMLA leave.

## **Cost**

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### **Cost of Coverage**

The Company pays a portion of your medical coverage. You pay your portion of the cost through payroll deductions. This is known as your Premium.

To help lower your cost, your contributions are deducted from your pay on a pretax basis.

Your contributions for Plan coverage are based on the level of coverage you choose. The coverage levels are:

- Employee;
- Employee + Spouse / Domestic Partner;
- Employee + child(ren) / Domestic Partner child(ren); and
- Employee + family.

If you elect medical coverage for your nontax-qualified Domestic Partner or Domestic Partner's Dependents, you will be responsible for the imputed income tax. That means that the portion of the Company-paid contributions that is for your nontax-qualified Domestic Partner and your nontax-qualified Domestic Partner's Dependents will be added to taxable income. The Company's contribution toward nontax-qualified Domestic Partner coverage will, in most cases, be considered imputed income and will be taxable income to you. In addition, the Premiums that you pay that are attributable to nontax-qualified Domestic Partners or their Dependents may not be paid by you on a pretax basis.

Your Premiums are subject to change (but normally not more often than annually). In general, any adjustments will be effective January 1. You will be notified in advance of any rate changes.

## **Deductibles**

The Deductible is the amount of money you must pay each Plan Year for Covered Services before the Plan begins to pay benefits for services at the applicable Coinsurance rate. Under the Plan, you are subject to a Deductible for In-Network and Out-Of-Network expenses. The Plan has both Individual and Family Deductibles. Deductible amounts are based on the level of coverage you elect.

Expenses for Prescription Drugs are not subject to the Deductible and do not apply toward your Deductible. However, these expenses do apply toward the Out-of-Pocket Maximum.

### **Individual Deductible**

The Individual Deductible applies to each Member. Once you meet the Individual Deductible, the Plan begins paying benefits for non-preventive care services at the applicable Coinsurance rate. Once you pay the Out-Of-Network Deductible, you do not need to pay an additional In-Network Deductible. Also, if you pay your In-Network Deductible, you can apply it to your Out-Of-Network Deductible and pay the difference if you incur Out-Of-Network expenses.

### **Family Deductible**

The Family Deductible is met after Covered Expenses have been incurred in total by two or more covered family members during a Plan Year. When this happens, the Deductible for the entire family is satisfied for the remainder of that Plan Year.

### **Annual Out-of-Pocket Maximum**

The annual Out-of-Pocket Maximum is the maximum amount you pay for your share of Covered Expenses each year.

### **Individual Out-of-Pocket Maximum**

The individual Out-of-Pocket Maximum applies if you have employee only coverage or to each individual if you are covering more than just yourself. Expenses for the In-Network Out-of-Pocket Maximum also apply to the Out-of-Network Out-of-Pocket Maximums.

### **Family Out-of-Pocket Maximum**

To meet the family Out-of-Pocket Maximum, all family members' eligible out-of-pocket expenses combined count toward the family Out-of-Pocket Maximum.

Once the family Out-of-Pocket Maximum has been reached, the plan pays 100% of the contracted rate of In-Network covered costs and 100% of the Reasonable Charge of Out-Of-Network covered costs, for all covered members. There are no individual limits under this plan. Refer to the **REASONABLE CHARGE** section for more information.

Expenses that count toward your annual Out-of-Pocket Maximum include:

- Coinsurance;
- Deductible;

- retail Prescription Drugs, including copays and minimum amounts;
- mail order Prescription Drugs, including Copays; and
- Specialty Prescription Drugs, including Copays.

These expenses do not apply to the Out-of-Pocket Maximum:

- charges above the Reasonable Charge;
- charges that exceed individual benefit maximums;
- dental charges covered by the dental plan;
- dental deductibles;
- expenses for services that are not Medically Necessary or are not covered by the Plan; and
- Plan penalties.

### Lifetime Maximum Benefit

The lifetime maximum benefit is the limit the Plan will pay in each Member's lifetime. There is no lifetime maximum on overall benefits; however there are maximums on specific benefit categories. Lifetime maximum benefits are: \$15,000 fertility treatment, per family

## Plan Benefit

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### Schedule of Benefits

Plan feature	PPO Plan	
	In-Network Coverage	Out-of-Network Coverage
<b>Your Doctor</b>	You choose an In-Network Provider	You choose an Out-of-Network Provider
<b>Annual <u>Deductible</u> - amount you must pay before the Plan pays benefits</b>	Single \$1,000 Family \$2,000 (individual limit applies per person) Plan Coinsurance 80% of the contracted rate	Single \$2,000 Family \$4,000 (individual limit applies per person) Plan Coinsurance 50% of the Reasonable Charge
<b>Annual <u>Out-of-Pocket Maximum</u> - highest amount of Covered Expenses you pay per year</b>	Out-of-Pocket Maximum (includes Deductible): Single \$4,000 Family \$8,000 (individual limit applies per person)	Out-of-Pocket Maximum (includes Deductible): Single \$8,000 Family \$16,000 (individual limit applies per person)
<b>Lifetime Maximum</b>	Unlimited	

<b>Medical - Physician Services</b>		
<b>Primary care office visit (including Telehealth)</b>	\$25 Copay	50% of the Reasonable Charge
<b>Specialty care office visit</b>	\$40 Copay	50% of the Reasonable Charge
<b>Allergy testing</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Allergy shots</b>	80% of the contracted rate when rendered in the Physician office	50% of the Reasonable Charge
<b>Maternity care</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Anesthesia, radiology, pathology</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Inpatient Medical – Facility (Plan payments after you meet Deductible)</b>		
<b>General Hospital (room &amp; board and ancillary facility services)</b>	80% of the contracted rate	50% of the Provider's rate
<b>Inpatient Medical - Professional Services (Plan payments after you meet Deductible)</b>		
<b>Anesthesiologist</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Radiologist</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Pathologist</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Physician/surgeon Providers</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Outpatient Medical – Facility (Plan payments after you meet Deductible)</b>		
<b>Emergency room/Emergency care</b>	\$150 Copay	80% of the Provider's rate
<b>Laboratory</b>	80% of the contracted rate in a Hospital or outpatient facility and 80% of the contracted rate in an office setting	50% of the Reasonable Charge in a Hospital facility and 50% of the Reasonable Charge in an office setting
<b>Radiology</b>	80% of the contracted rate	50% of the Provider's rate
<b>Observation room</b>	80% of the contracted rate	50% of the Provider's rate
<b>Therapies &amp; Other Services (Plan payments after you meet Deductible)</b>		
<b>Physical therapy</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Speech therapy</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Dyslexia and ADHD</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Respiratory therapy</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Chemotherapy</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Radiation therapy</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Chiropractic services (excludes diagnostics such as lab and x-rays)</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Mental Health (Inpatient)</b>	80% of the contracted rate	50% of the Provider's rate
<b>Mental Health (Outpatient)</b>	80% of the contracted rate	50% of the Reasonable Charge

<b>Substance Abuse Services (Inpatient)</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Substance Abuse Services (Outpatient)</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Skilled nursing facility</b>	80% of the contracted rate (365 days in- and Out-of-Network combined)	50% of the Provider's rate (365 days in- and Out-of-Network combined)
<b>Extended care facility</b>	80% of the contracted rate	50% of the Provider's rate
<b>Rehabilitation facility</b>	80% of the contracted rate	50% of the Provider's rate
<b>Home health services &amp; supplies</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Ambulance (Emergency only)</b>	80% of the contracted rate (only if Medically Necessary, not just for transportation)	80% of the Reasonable Charge (only if Medically Necessary, not just for transportation)
<b>Hospice</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Durable Medical Equipment(DME) / Prosthetics</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Diabetes Education</b>	80% of the contracted rate	50% of the Reasonable Charge
<b>Infertility (includes treatment and drugs)</b>	80% of the contracted rate (\$15,000 lifetime maximum combined In-Network and Out-of-Network, per family)	50% of the Reasonable Charge (\$15,000 lifetime maximum combined In-Network and Out-of-Network, per family)
<b>Preventive services</b>		
<b>Preventive immunizations</b>	100% of the contracted rate	100% of the Provider rate
<b>Preventive Care Benefit (including labs)</b>	Plan pays 100% (not subject to Deductible or Out-of-Pocket Maximum)	None

## Covered Services

Under the Plan, the following services are covered at the standard benefit amount:

- acupuncture;
- assistant surgeon fees;
- blood and blood plasma;
- circumcision;
- doctor's office visits;
- Hospital room and board at the semi-private room rate;
- occupational therapy;

- physical therapy;
- pre-admission surgical testing;
- retail, mail order and specialty pharmacy;
- surgeon fees;
- laboratory tests;
- x-rays; and
- chiropractic services.

Refer to the specific sections for information about Prescription Drugs, Preventive Care, Emergency Room, Hospice Care, Mental Health Conditions, Substance Abuse and Maternity Hospital Stay.

The Plan covers the following, based on certain rules and restrictions specified in this document:

- allergy test and treatment;
- ambulance service to the nearest Hospital;
- birthing center if it is a freestanding unit or a separate wing of a qualified Hospital with Emergency transport facilities in case complications require immediate transfer of the mother or child to the Hospital;
- breast implant after mastectomy;
- dental treatment for accidental injury when performed within 12 months of the accident or injury to the jaw or to sound natural teeth, or removal of impacted wisdom teeth;
- diagnostic tests including x-ray and lab tests;
- hearing care, including cochlear implants when medical necessary. Excludes and audiometric exams;
- Hearing aids purchased to correct general hearing loss associated with aging for dependent children up to age 26. Diagnoses for adults that appear to be for specific medical conditions and not aging will be reviewed on a case by case basis for coverage.
  - Hearing aid may be replaced once every 3 years. Excludes batteries and repairs. Cochlear implants for adult and children (ages consistent with FDA indications) are covered for the following diagnosis: severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or post-lingual sensorineural deafness in an adult. Coverage to include the hearing aid, dispensing fee, molds, and impressions
- Home Health Care for services provided by a state- or locally-licensed Home Health Care Agency qualified by Medicare to provide skilled nursing and other therapeutic services. Covered Services include: skilled nursing care, home health aid service, rehabilitative care, occupational, vocational, speech, physical

and respiratory therapy, medical and surgical supplies and nutritional guidance therapy. All care must be supervised by a registered nurse or a doctor;

- maternity care;
- penile implants; must meet “medical necessity”;
- Skilled Nursing Facility expenses including semi-private room and board, nursing care, x-rays and laboratory examinations, physical, occupational or speech therapy, oxygen and gas therapy, drugs, solutions, dressings and casts, other related service customarily provided to patients;
- speech therapy;
- transgender related services, including sex reassignment surgery: and
- services related to the diagnosis or treatment of autism, hyperkinetic syndrome, learning disabilities, developmental delays or mental retardation include speech, occupational therapy, physical therapy, ABA, psychological services, and assistive devices.

Refer to the **DICTIONARY TERMS** section for a list of definitions for Covered Services.

### **Accident Related Dental Services**

Generally, dental expenses are not covered under the Plan. However, Outpatient Services, Physician Office Services, Emergency Care Services and Urgent Care Services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face. Injury as a result of chewing or biting is not considered an accidental injury, except when the injury is caused by a medical condition or domestic violence.

### **Ambulance Services**

Transportation by a vehicle designed, equipped and used only to transport the sick and injured is covered:

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

Air transport requires medical policy / review requirements.

### **Christian Science**

Benefits are payable under this Plan for:

- charges incurred for present and absent treatment for healing purposes made by a Christian Science practitioner. At the time such treatment is made, the practitioner must be accredited by the Mother Church, The First Church of Christ Scientist, in Boston, Massachusetts. Such charges are subject to the same terms and conditions as if they had been made by a doctor;



- charges incurred for private nursing care and made by a Christian Science nurse. At the time such treatment is rendered, the nurse must be accredited by the Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts. Such charges are subject to the same terms and conditions as if they had been made by a registered nurse (R.N.); and
- charges incurred for room and board while confined for healing purposes in a Christian Science Sanatorium. The sanatorium must be: (a) currently maintained by the Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts; or (b) accredited by the Committee on Christian Science Nursing Homes of the Mother Church. Such charges are subject to the same terms and conditions as if the charges had been incurred in a Hospital.

### **Diabetes Self-Management Training**

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

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

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

### **Diagnostic Services**

Coverage for Diagnostic Services includes but is not limited to:

- x-ray and other radiology services;
- laboratory and pathology services;
- cardio graphic, encephalographic, radium and radioisotope tests;
- ultrasound services; and
- allergy tests.

### **Elective Abortion**

Regardless of Medical Necessity, the Plan provides benefits for Covered Services for elective abortion.

### **Emergency Care and Urgent Care**

It is important to know the difference between Emergency and Urgent Care situations.

## **Emergency Care**

Medically Necessary Emergency Care services that the Claims Administrator determines to meet the definition of an Emergency will be covered, whether the care is rendered by an In-Network Provider or Out-of-Network Provider. Emergency Care rendered by an Out-of-Network Provider will be covered at the In-Network level. Emergency Care is available 24 hours a day, 7 days a week. Follow-up care is not considered Emergency Care.

Whenever you are admitted as an Inpatient directly from a Hospital Emergency room your treatment will be considered an Emergency. For Inpatient admissions following Emergency Care, you, your Physician, or the Hospital should contact the Claims Administrator within 48 hours of admission or as soon as reasonably possible in order to obtain authorization for a specific length of stay. When the Claims Administrator is contacted for authorization, you will be notified of the number of days considered Medically Necessary for your diagnosis. Thus, you may avoid having to pay charges for any excessive Inpatient days that are not Medically Necessary.

Care and treatment once you are stabilized is not Emergency Care. Continuation of care from an Out-of-Network Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as Out-of-Network unless the Claims Administrator authorizes the continuation of care and it is Medically Necessary. The applicable Coinsurance will apply for non-Emergency Care.

In order for an Emergency room expense to be approved the medical circumstances must meet the definition of Emergency.

If you have questions regarding the Emergency status of a medical condition contact the Claims Administrator at the telephone number on the back of your Identification Card.

## **Urgent Care**

Often an Urgent rather than an Emergency medical problem exists. Urgent Care services can be obtained from any Provider. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition requires Urgent Care or Emergency Care, based on your diagnosis and symptoms.

Urgent Care is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not an Emergency and does not require use of an Emergency room at a Hospital.

## **Home Care Services**

Home Care Services are performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services may include the following:

- intermittent skilled nursing services (by an R.N. or L.P.N.);
- diagnostic services;

- therapy services (visit limits specified in the Schedule of Benefits do not apply when rendered in the home);
- medical/surgical supplies;
- durable medical equipment; and
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

Home infusion therapy is covered and includes a combination of nursing, durable medical equipment, and pharmaceutical services that are delivered and administered intravenously in the home. Home Infusion therapy includes services and supplies for total parenteral nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management, and home chemotherapy.

### **Hospice Care Services**

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

Covered Services include the following:

- skilled nursing services (by an R.N. or L.P.N.);
- diagnostic services;
- physical, speech and inhalation therapies;
- medical supplies, equipment and appliances;
- counseling services (except bereavement counseling);
- Inpatient confinement at a Hospice; and
- Prescription Drugs obtained from the Hospice.

### **Human Organ and Tissue Transplant Services**

Covered transplant procedures include any of the following Medically Necessary "Human Organ and Tissue Transplants (HOTT)" performed in an approved HOTT Participating Transplant Facility. Utilizing the In Network Blue Distinction Transplant Center (BDTC) will provide the maximum benefit, otherwise the coverage level is 50%.

HOTT benefits are subject to the Plan's Deductible and Out of Pocket.

Adult procedures include:

- bone marrow or stem cell;
- autologous bone marrow including high dose chemotherapy;
- related allogeneic bone marrow including high dose chemotherapy;
- unrelated allogeneic bone marrow including high dose chemotherapy;
- heart;

- heart/lung;
- lung;
- liver;
- kidney and
- pancreas

Pediatric procedures include:

- bone marrow or stem cell;
- autologous bone marrow including high dose chemotherapy;
- related allogeneic bone marrow including high dose chemotherapy;
- unrelated allogeneic bone marrow including high dose chemotherapy;
- heart;
- liver.

As additional diagnoses cease to be Experimental/Investigative, the Plan may amend the above covered transplant procedure list to include such procedures.

When a Human Organ or Tissue Transplant is considered to be Experimental/Investigative, the transplant and all Covered Services performed in relation to the transplant are excluded under the Plan. If a covered Human Organ or Tissue Transplant is done in conjunction with an Experimental/Investigative transplant the Claims Administrator, on behalf of the Plan Administrator, will determine the portion of the charges that relate to the covered Human Organ or Tissue Transplant and allow only those charges.

### **Prior Approval**

In order to receive benefits for a transplant, you or your Provider must call the Claims Administrator for a pre-determination of benefits as soon as you become aware a transplant is needed. If benefits are approved through pre-determination, you or your Provider must call the Claims Administrator's Transplant Department at 1-800-824-0581 for Precertification prior to the transplant.

### **Transplant Plan Year**

Transplant benefits start one day prior to the organ transplant surgery or one day prior to myeloablation therapy (high dose chemotherapy and/or irradiation). Any services performed more than one day prior to the transplant are eligible for benefits under the medical portion of the Plan with the exception of services in conjunction with bone marrow transplant/stem cell harvesting.

Transplant benefits end the earlier of the following:

- 364 days from the date of the transplant surgery or first myeloablation therapy; and
- the day before a re-transplant, if within one year (upon re-transplant a new transplant plan year starts).

Immunosuppressant drugs administered beyond the transplant benefit period may be covered under the medical benefit and are not covered under this transplant benefit.

### **Transportation, Lodging and Meals**

Reasonable Charges for transportation expenses, as determined by the Claims Administrator, to and from the site of the covered transplant procedure, including meals and lodging while at the site of the covered transplant, are covered for the Member. These expenses will also be covered for a companion if the facility is more than 75 miles from the Member's residence. If the Member is a minor, then reasonable and necessary expense for transportation, lodging and meals may be allowed for two companions. In order to receive reimbursement for transportation, meals and lodging, the Member must submit itemized receipts to the Claims Administrator. Contact the Claims Administrator's Transplants Department for detailed information.

### **Procurement**

Procurement is included in the covered transplant procedure. Cord blood is payable if the transplant is approved. Harvesting and storage of cord blood bone marrow or stem cells for a possible future transplant are not eligible under this transplant benefit.

### **Transplant Related Expenses**

Transplant related expenses mean Medically Necessary items that are required as a result of a covered transplant and would not be incurred if the person were not having a covered transplant. Services related to the diagnosis causing the need for a covered transplant that would have been performed whether or not the patient received a covered transplant are not considered a transplant related expense. Transplant related expenses during a transplant plan year include only the following:

- acquisition costs (live or cadaver). Acquisition costs include Medically Necessary services in connection with the preparation, collection and storage of bone marrow, stem cell or solid organ for a covered transplant. For a living donor, acquisition costs also include the Medically Necessary Inpatient services for the recovery of the donor post-surgery and any complications that arise as a direct result of the actual acquisition procedure for a period of six weeks from the date of the acquisition or as otherwise determined within the limits determined by the Claims Administrator;
- Reasonable Charges for transportation expenses for the patient and one companion to and from the site of the covered transplant procedure and lodging and meals for the patient and a companion while at the site of the covered transplant within limits determined by the Claims Administrator. If the patient is a minor, then expenses for transportation, lodging and meals may be allowed for two companions;
- Hospital charges and professional fees for the covered transplant procedure;
- pharmacy charges for immunosuppressant drugs, and other Prescription Drugs required for other post-surgical complications, and Prescription Drugs required as a result of the patient being immunosuppressed;

- Inpatient services, Outpatient services, or Home Care services for treatment of complications of bone marrow or stem cell transplant, or for complications and/or rejection of the transplanted organ; and
- Physician fees for medical care following Hospital discharge, which are identified as post-transplant.

## **Inpatient Facility Services**

### **Room, Board, and General Nursing Services**

Covered Services for room, board, and general nursing services shall include:

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

### **Ancillary Services**

Covered Services for ancillary services:

- operating, delivery, and treatment rooms and equipment;
- prescribed drugs dispensed by Hospital during confinement;
- anesthesia, anesthesia supplies and services given by an employee of the Hospital or other facility Provider;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services; and
- therapy services.

### **Maternity Services**

Inpatient Hospital coverage for a mother and her newborn child will be at a minimum, 48 hours for a vaginal delivery and 96 hours for a caesarian section. Coverage for a stay in excess of this requires Precertification by the Claims Administrator. However, the mother's attending Physician, after consulting with the mother, may discharge the mother or the newborn earlier than the minimum period mentioned above.

At-home post-delivery follow-up care visits are covered when the mother and child are discharged from the Hospital before the minimum period described above. Care is available for you at your residence, or your Physician's office, by a Physician or nurse when performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for these visits includes, but is not limited to:

- assessment of the home support system;
- assistance and training in breast or bottle feeding;

- parent education;
- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening; and
- physical assessments.

### **Breast pumps & Supplies:**

Benefits for breast pumps include the cost of purchasing or renting one manual or electronic breast pump per year. Breast pumps are covered with no cost sharing when bought at retail stores, pharmacies, or through a durable medical provider.

Reimbursement includes the cost of the breast pump and taxes. Additional breast pump supplies purchased at retail stores are not covered.

### **Medical Supplies, Equipment and Appliances**

The supplies, equipment and appliances described below are covered under this benefit. However, certain approved supplies and equipment are covered under the Prescription Drug benefit when they are obtained by mail order or from an In-Network pharmacy. If the supplies, equipment and appliances include comfort, luxury, or convenience items that are not Medically Necessary, the amount of benefits is the Reasonable Charge for the eligible standard item. Any expense that exceeds the Reasonable Charge for standard item is your responsibility. The Plan covers:

- medical and surgical supplies including syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like band-aids, thermometers, and petroleum jelly;
- prosthetic appliances benefits including: the first lenses(s) or glasses following cataract surgery; breast prostheses and 2 surgical brassieres each Plan Year following a mastectomy; and the first wig following cancer treatment;
- prosthetic appliances including the purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that: replace all or part of a missing body organ and its adjoining tissues; or replace all or part of the function of a permanently useless or malfunctioning body organ; and
- durable medical equipment including the rental (or, at the Claims Administrator's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Rental costs must not be more than the purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use. Repair of medical equipment is covered. Certain types of durable medical equipment require precertification. Contact the Claims Administrator for a complete list of these items. Non-covered equipment includes items such as air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports, and corsets or other articles of clothing.

## **Mental Health/Substance Abuse Services**

Inpatient Services, Outpatient Services, and Physician Office Services for the treatment of Mental Health Conditions or Substance Abuse are covered for the diagnosis, crisis intervention, and short-term treatment of Mental Health Conditions or for detoxification and/or rehabilitation of Substance Abuse. Benefits are limited as specified in the Schedule of Benefits.

### **Inpatient Services**

Inpatient Services to treat Mental Health Conditions or Substance Abuse include:

- individual psychotherapy;
- group psychotherapy;
- psychological testing;
- family counseling with family members to assist in your diagnosis and treatment; and
- convulsive therapy, including electroshock treatment or convulsive drug therapy.

### **Partial Hospitalization Services**

The services covered for Mental Health Conditions/Substance Abuse Inpatient Services are also covered for partial hospitalizations. A partial hospitalization may be substituted for Inpatient benefits at two days for each available Inpatient day.

### **Outpatient Services**

The services covered for Mental Health Conditions/Substance Abuse Inpatient Services are also covered for Outpatient (except room, board, and general nursing service).

Residential services for treatment of Mental Health Conditions or Substance Abuse, may be covered by a \$25,000 lifetime maximum benefit for members, if those services are deemed not “medically necessary” per Anthem’s criteria.

### **Outpatient Services**

Outpatient Services include facility and professional charges for surgical services, diagnostic services, and therapy services when rendered as an Outpatient at a Hospital or other Provider.

For Emergency Care refer to the **EMERGENCY CARE AND URGENT CARE** section.

Note: A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy and who elects breast reconstruction, will also receive coverage for:

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



## **Preventive Care Services**

Under the Plan, expenses for all Covered Services are subject to the Deductible and then Coinsurance or copays, with the exception of certain preventive care medical services, which are covered at 100%. These preventive care services are covered In-Network only and include the following:

- preventive diagnostic testing (including lab tests and x-rays);
- adult physicals;
- child physicals;
- preventive PSA tests;
- colonoscopies (routine and diagnostic);
- Cholesterol screening
- preventive pediatric exams;
- preventive hearing evaluations and routine screenings; and
- Preventive immunizations -- both pediatric and adult -- including flu shots, are covered at 100% for both In- and Out-of-Network services.

Note: This list is not all inclusive but rather representative of the types of services covered under the provision.

Refer to the **PRESCRIPTION DRUG PLAN** section for specific information about how drugs are treated.

## **Women's Preventive Health**

Under the Plan, expenses for all Covered Services are subject to the Deductible and then Coinsurance or copays. However, the Plan covers expenses for certain preventive care medical services at 100%. This includes the following Women's Preventive services when services are received In-Network.

- Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, including gynecology visits, pap smears, and mammograms. Mammograms and pap smears are covered at the preventive level regardless of diagnosis.
- Human papillomavirus testing; beginning at age 30 and no more frequently than every 3 years
- Screening for gestational diabetes - In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes
- Counseling for sexually transmitted infections
- Counseling and screening for human immune-deficiency virus
- Screening and counseling for interpersonal and domestic violence

## **Physical Medicine and Rehabilitation Services**

Coverage for Inpatient Services is available for a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible. This includes skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a Social Worker and a Psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

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

## **Professional Services**

### **Physician Office Services**

Office visits include but are not limited to medical care and consultations to examine, diagnose and treat an illness or injury performed in the Physician's office. Office services also include:

- diagnostic services when required to diagnose or monitor a symptom, disease or condition; and
- surgery and surgical services including anesthesia and supplies. The surgical fee includes normal post-operative care.

### **Inpatient Physician Services**

Inpatient services include the following:

- professional services from a Physician while an Inpatient;
- intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time;
- concurrent care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians;
- consultation that is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded;
- surgery and the administration of anesthesia; and
- newborn examinations by a Physician other than the Physician who performed the obstetrical delivery.

## **Sterilization**

Regardless of Medical Necessity, you are covered for sterilization. Sterilization reversals have a lifetime limit of one per Member.

## **Surgical Services**

Coverage for Surgical Services when provided as part of Physician office services, Inpatient services or Outpatient services is limited to the following:

- performance of generally accepted operative and other invasive procedures;
- the correction of fractures and dislocations;
- anesthesia and surgical assistance when Medically Necessary;
- usual and related pre-operative and post-operative care; and
- other procedures as approved by the Claims Administrator.

The surgical fee includes normal post-operative care.

## **Therapy Services**

Coverage for therapy services when provided as part of Physician office services, Inpatient services, Outpatient services, or Home Health Care services is limited to the following:

- Physical Medicine Therapies (coverage is provided when the therapy is expected to result in a practical improvement in the level of functioning within a reasonable period of time):
  - physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part;
  - speech therapy for the correction of a speech impairment resulting from illness, injury, or surgery; and
  - occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. It also includes those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, and vocational therapies (such as hobbies, arts, and crafts).
- Other Therapy Services:
  - cardiac rehabilitation to restore an individual's functional status after a cardiac event. Home programs, ongoing conditioning and maintenance are not covered. The charges for exercise bicycles are covered up to \$500 for those participants who have open heart surgery or post-myocardial infarction. These participants must be enrolled in a recognized cardiac rehabilitation program;
  - chemotherapy for the treatment of disease by chemical or biological antineoplastic agents;
  - dialysis treatments of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine;

- radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes; and
- Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

See your Schedule of Benefits for benefit limitations.

## **Network Information**

### **Network of Doctors and Hospitals**

There is a network called Blue Access PPO-Anthem Blue Cross Blue Shield, which includes general practitioners, as well as specialists and Hospitals. If you live and work in the state of Wisconsin your network is called Blue Preferred Primary-Anthem Blue Cross Blue Shield. If you live and work in Wisconsin and your covered child resides outside of Wisconsin, your child will have the Blue Access PPO-Anthem Blue Cross Blue Shield.

You get the higher level of benefits when you get care from In-Network Providers.

### **Getting a Listing of Providers**

The Providers that are In-Network are listed on the Claims Administrator's website (go to [www.anthem.com](http://www.anthem.com), then click on "Providers," then click on Find a Doctor on the next page). You can also find out if a Provider is in the network by calling the Claims Administrator's Member Advocate Department. The number is located on the back of your Identification Card.

### **Precertification**

Under the Plan certain non-Emergency services require Precertification to be covered by the Plan. You must get Precertification from the Claims Administrator for:

- diagnostic services for positron emission tomography (PET) and single photon emissions computed tomography (SPECT);
- durable medical equipment/prosthetics: a) wheelchairs (special size, motorized or powered and accessories), b) Hospital beds, rocking beds, and airbeds, c) electronic or externally powered prosthetics, and d) custom made orthotics and braces;
- Home Care Services; including Private Duty Nursing
- Inpatient admissions to Hospitals and other covered facilities; however, Precertification is not required for maternity admissions resulting in childbirth that are 48 hours for a vaginal delivery and 96 hours for C-section delivery. Newborn stays beyond the Mother require precertification.
- plastic/reconstructive surgeries for: a) blepharoplasty, b) rhinoplasty/ceftoplasty, c) hairplasty, d) panniculectomy and lipectomy/diastasis recti repair, e) pectus excavatum repair, f) insertion/injection of prosthetic material collagen implants, g) chin implant/mentoplasty/osteoplasty mandible, and, h) lip/cleft, lip/palate repair; and

- uvulopalatopharyngoplasty (UPPP) surgery;
- Bariatric Procedures;
- Elective Admissions;
- Long Term Acute Care Facility, Rehabilitation Facility and Skilled Nursing Facility admissions.
- Inpatient Behavioral Health and Substance Abuse treatment, Intensive Outpatient Therapy, or Partial Hospitalization
- Electric Convulsive Therapy

The Precertification administrator is a professional team of nurses and board-certified doctors that, when appropriate, provides you with information about your treatment options. You and your Physician make the final decision, but the Plan does not cover services that are not Precertified.

### **Second Surgical Opinions**

You do not need a second surgical opinion for In- or Out-of-Network surgery, but a second opinion is a Covered Expense and may help you determine whether surgery is really necessary.

### **Health Care Management**

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

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by assuring the use of appropriate procedures, setting (place of service), and resources using Precertification, Concurrent Review, and Case Management.

### **Concurrent Review**

Concurrent Review is a process in which nurses monitor your progress during an Inpatient admission. As a result of Concurrent Review, additional days of Inpatient care may be approved that exceed the number originally authorized by the Claims Administrator's Health Care Management staff. With prior notice by the Claims Administrator, the number of days originally authorized through Precertification may be reduced when it is determined that continued Inpatient care is no longer Medically Necessary.

### **Case Management (Includes Discharge Planning)**

Case Management is a feature designed to assure that your care is provided in the most appropriate and cost effective care setting. The Case Management process can include:

- an assessment of the Member's condition; and
- available resources and treatment options.

This feature allows the Claims Administrator to customize your benefits by approving otherwise non-Covered Services or arranging an earlier discharge from an Inpatient

setting for a patient whose care could be safely rendered in an alternate setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Claims Administrator's Health Care Management staff. In managing your care, the Claims Administrator has the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

### **Care Management Tools and Resources**

As a participant in this Plan, you and your family have access to care management resources.

- **Nurse Line:** The Nurse Line gives you a direct, toll-free connection to a registered nurse anytime of day or night at 1-866-691-8432.
- **Care Management:** If you or a Dependent live with a chronic disease or health condition, the Plan offers confidential services designed to help improve both your health and your quality of life. If you or a covered Dependent qualify to participate in a care management program, a program representative will call and invite you to join. Examples of care management programs include help with managing one of the following conditions:
  - asthma;
  - atrial fibrillation;
  - COPD (emphysema or chronic bronchitis);
  - diabetes;
  - heart disease;
  - heart failure;
  - high blood pressure;
  - high cholesterol;
  - low back pain; and
  - stroke.
- **Maternity Management:** As an added benefit under the Plan, you or your covered Dependent may enroll in the Maternity Management Program. This program is designed to help identify potential risk factors, as well as promote a healthy pregnancy and delivery. Maternity Management also provides you with relevant information and education materials.
- **Case Management:** If you have a catastrophic health event, Case Management can assign a specially trained nurse advocate (backed by a team of board-certified Physicians) to help you navigate the healthcare system and help you coordinate your care as you progress from one caregiver to another.

Your health information that is used in the Plan and in these Care Management Tools is confidential and protected by federal law. See the **PRIVACY OF PROTECTED HEALTH INFORMATION** section for more information.

## Restrictions and Exclusions

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### Expenses not covered

The Plan does not cover the following:

- Charges for completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Charges for court ordered services.
- Charges for Custodial Care, domiciliary or convalescent care.
- Hearing aids/assistance needed for normal aging/noise exposure is not covered.
- Charges for maintenance services which are activities performed to preserve the level of function or prevent regression of function for an illness, injury or condition which is resolved or stable.
- Charges for mileage costs or other travel expenses (except as authorized by the Claims Administrator), transportation (except for transportation by ambulance services to a Hospital if Medically Necessary, including any transfers required by the medical condition, but not for the convenience, of the Member).
- Charges for missed or cancelled appointments.
- Charges for personal hygiene and convenience items (e.g., television, private rooms, housekeeping services, guest meals and accommodations, telephone charges, etc.), except as specified elsewhere in this Plan.
- Charges for which you have no legal obligation to pay.
- Charges in excess of the Reasonable Charge as determined by the Claims Administrator.
- Charges incurred after the termination date of coverage under the Plan except as specified elsewhere in this Plan.
- Charges incurred prior to your Effective Date.
- Cosmetic services, cosmetic drug therapy or reconstructive procedures, and any related services or supplies which alter appearance but are not Medically Necessary to restore or improve impaired physical function. Notwithstanding the foregoing, this exclusion does not apply when Covered Services are performed for: (a) repair of a defect resulting from an accident; (b) reconstructive surgery necessary for the prompt treatment of a diseased condition, or previous therapeutic process if recommended and performed by a licensed Physician; (c) reconstructive breast surgery on which a mastectomy has been or will be performed or surgery, reconstruction of the other breast to produce a symmetrical appearance in connection with a mastectomy, or prostheses and surgeries or procedures related to physical complications at all stages of the mastectomy (including lymphedemas); and (d) reconstructive surgery necessary as a result of conditions initially caused by a previous elective procedure, or treatment of a birth defect in a child that is otherwise covered under the Plan.

- Dental work, treatment or dental x-rays. This exclusion does not include: (a) oral dental surgery, performed while the Member is an Inpatient and whose admission to a Hospital facility is ordered by a Physician because the life or health of the Member will be placed in danger if such surgery is done while the Member is not an Inpatient (in such a case oral dental surgery is limited to charges for cutting procedures for diseases or the extraction of impacted teeth; and (b) such treatment that is necessitated by an accidental injury to sound natural teeth or to the jaw that is otherwise covered under the Plan.
- Food supplements.
- Physical exams required for enrollment in any insurance program, as a condition of employment for licensing, or for other reasons, except as specified in the Schedule of Benefits.
- Research studies or screening examinations, except as specified elsewhere in this Plan.
- Services related to vocational rehab, adult day programs, school related assistance or custodial care.
- Stand-by charges of a Physician.
- Items or equipment which are non-medical (not primarily and customarily used to service a medical purpose in the absence of illness or injury) such as exercise bicycles, treadmill equipment, physical fitness and athletic training equipment, air conditioners, humidifiers, hot tubs, saunas, whirlpools, physical exercise equipment, or electronic air filters, even though recommended by a physician.
- Medical services or supplies received as a result of any act of war (whether declared or not), riot, insurrection, civil disobedience, nuclear explosion, or nuclear accident.
- Orthoptic training.
- Services and supplies in a Veterans' Administration Hospital for a Member with a military service connected disability, except where required by law.
- Services and supplies that are not Medically Necessary, even if ordered by a Physician.
- Services and supplies which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Claims Administrator.
- Services and supplies which are not accepted in healthcare practice as needed in the diagnosis or treatment of the patient.
- Services and supplies which are not ordered by a Physician.
- Services for any condition, disease, defect, ailment, or accidental injury arising out of and in the course of employment if benefits are available under any Workers' Compensation or Occupational Disease Act or other similar law. This



exclusion applies if you receive the benefits in whole or in part; whether or not you claim the benefits or compensation and whether or not you recover from any third party.

- Services or supplies for which a Member would not legally have to pay if there were no coverage.
- Services received from a dental or medical department maintained by mutual benefit association, labor union, trust or similar person or group.
- Services prescribed, ordered, or referred by, or received from a member of your immediate family (including parent, child, Spouse, sister, or brother).
- Services which are not specified in the Plan as Covered Services even if Medically Necessary or prescribed by a Physician.
- Orthopedic shoes.
- Surgical procedures performed for the purpose of correcting myopia (nearsightedness), hyperopia (farsightedness), astigmatism, and expenses related to such procedures.
- Vitamins unless deemed to be Medically Necessary.
- Charges for maternity services related to a Member's service as a surrogate mother.
- Charges for physical, psychiatric or psychological examinations, testing or treatment not otherwise specifically listed in the Plan as covered benefits, for purposes: (a) of obtaining or maintaining employment or insurance; (b) compliance with judicial or administrative proceedings or orders; (c) which are conducted for purposes of medical research; (d) to obtain or maintain a license or certification of any type; (e) relating to travel; (f) relating to marriage or adoption; (g) required physical examinations related to sports participation beyond grade 12; (h) Physician certification for Medicaid or Medicare services; or (i) functional capacity testing. This exclusion does not apply to immunizations for travel.
- Radial keratotomy, or keratomileusis or excimer laser photo refractive keratectomy, laser surgery, and other types of eye procedures to correct refractive errors.
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture except when rendered by a Physician, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST) and iridology-study of the iris.
- Genetic counseling, screening or treatment that is not Medically Necessary.
- Medical fast diets, weight loss programs and educational dietary counseling related to weight-loss efforts.

- All non-prescription, patent or proprietary medicine or medication not requiring a prescription (other than insulin and specific medications as listed in the **PRESCRIPTION DRUG PLAN**, or prescription drugs which may be properly received without charge under local, state or federal programs, including workers' compensation or any duplicate insurance program.
- Vocational rehabilitation.
- Health care services and related expenses for treatment of injuries incurred while in the commission of a felony, regardless of whether the Member is convicted or pleads to a lesser offense, if the Claims Administrator determines by a preponderance of the evidence that a felony was committed.
- Services and supplies related to any mechanical equipment, device, or organ. However, this exclusion does not apply to a left ventricular assist device when used as a bridge to a heart transplant.
- Any and all therapeutic devices, appliances, or treatment(s) prescribed or administered to treat any aspect of sexual dysfunction or enhancement, except as provided in the Prescription Drug Plan.
- Special diets at home including but not limited to nutritional products for inborn errors of metabolism (*i.e.*, PKU and carnitine deficiency), supplemental feedings, (*i.e.* Slimfast, Ensure, Sustacal) and maintenance enteral products, supplies and equipment.
- Charges related to donating and storage of blood or blood products.
- Prophylactic mastectomy and any subsequent reconstruction is not a covered benefit in members without a documented diagnosis of breast cancer and associated high risk factors.
- Any New FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Marital counseling.
- Eyeglasses, contact lenses, or other vision materials. 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.
- Expenses incurred at a health spa or similar facility.
- Self-help training and other forms of non-medical self-care, except as otherwise provided herein.
- Private duty nursing services rendered in a Hospital or Skilled Nursing Facility.

- Private duty nursing services except when provided through the Home Care Services benefit.
- Services, to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- Care received in an emergency room which is not Emergency Care, except as specified in this booklet.

### Pre-Existing Condition Limitation

There are no exclusions or limitations for Pre-Existing Conditions.

## Prescription Drug Plan

If you are enrolled in this Plan, the Prescription Drug benefit is available to help you and your covered Dependents pay for medication.

### Vaccines

100% coverage for the following vaccine when administered through medical or pharmacy plan:

Group	Vaccine
COVID-19	<ul style="list-style-type: none"> <li>• COVID-19 vaccines approved by the FDA</li> </ul>
Flu (seasonal influenza)	<ul style="list-style-type: none"> <li>• Influenza (trivalent, quadrivalent, cell-based, preservative free, intradermal, high dose, etc.)</li> </ul>
Hepatitis	<ul style="list-style-type: none"> <li>• Hepatitis A Virus</li> <li>• Hepatitis B Virus</li> <li>• Hepatitis B Virus, Hepatitis A Virus</li> </ul>
Pneumonia	<ul style="list-style-type: none"> <li>• Pneumococcal</li> </ul>
Shingles	<ul style="list-style-type: none"> <li>• Zoster-Shingles</li> </ul>
HPV	<ul style="list-style-type: none"> <li>• Human Papillomavirus</li> </ul>
Childhood Vaccines	<ul style="list-style-type: none"> <li>• Measles, Mumps &amp; Rubella (MMR)</li> <li>• Measles, Mumps, Rubella, Varicella</li> <li>• Varicella</li> <li>• Haemophilus influenzae B (combo)</li> <li>• Poliomyelitis</li> </ul>
Meningitis	<ul style="list-style-type: none"> <li>• Meningococcal</li> </ul>
Tetanus/Diphtheria/Pertussis	<ul style="list-style-type: none"> <li>• Tetanus Booster</li> <li>• DT, DTaP, Td, Tdap, TT (+ other combos)</li> </ul>
Travel Vaccines	<ul style="list-style-type: none"> <li>• Japanese Encephalitis</li> <li>• Typhoid</li> <li>• Yellow Fever</li> <li>• BCG</li> <li>• Rabies</li> <li>• Anthrax</li> </ul>

## Contraceptive

Prescription contraceptives will be covered at 100% with no cost sharing for women. Over the counter contraceptives will not be covered.

## Paying for Your Prescription Drugs

Your cost and the Plan's cost for Prescription Drugs is based on:

- the type of medication (Generic, preferred brand or non-preferred Brand Name Drug);
- where you fill your prescription; and
- the amount (or "supply") you order.

## Prescription Drug Schedule of Benefits

The following summary lists your responsibility for Prescription Drugs under the Prescription Drug program:

Type	Retail Pharmacy (up to 34-day supply) In- or Out-of-Network*	CVS or Walgreen Retail or Mail Order Program (up to 90-day supply) In-Network only
Generic	You pay \$10 Copay	You pay \$20 Copay
Brand-Name Formulary Drug	You pay \$40 Copay	You pay \$80 Copay
Brand-Name Non Formulary Drug	You pay \$80 Copay	You pay \$160 Copay

Your Plan uses a Formulary that is comprised of drugs in multiple classes (Generic, Preferred Brands, and non-Preferred Brands for both Specialty and non-Specialty medications) and in order to be covered the drugs must be specifically listed on one of the various tiers.

Through the Claims Administrator you can fill your prescription mainly in two ways: from a participating retail pharmacy or through the mail order program. You may also refill your prescriptions at the retail pharmacy or through the mail order program by using a mail-in form or the Claims Administrator's web site. On the site you will click on "mail service pharmacy" and be asked to provide your login and pass code.

## Retail Pharmacy Program

The retail pharmacy program is typically used when you need a prescription on a short-term basis, such as an antibiotic to treat strep throat or a child's ear infection. In most cases, up to a 34-day supply for each prescription/refill is available through an in-network retail pharmacy.

- There are nearly 60,000 participating Pharmacies throughout the U.S. An in-network pharmacy list is sent to you when you first enroll in the Plan. If you need a list, call the Claims Administrator at (866) 544-6968. You can also go to the Claims Administrator's Web site. You are encouraged to ask the pharmacist if they participate in the Claims Administrator's network.
- You must present your Medical/Prescription Drug Identification Card to the pharmacist who will tell you the amount you are required to pay. You do not have to file a claim form for prescriptions filled at an in-network pharmacy.
- If you purchase a Prescription Drug from an Out-of-Network pharmacy, you will be required to pay for the prescription at the time of your purchase. You may file a paper claim within 365 days to the Claims Administrator for review. In order to process the claim, the Claims Administrator will need the receipt and the National Drug Code (NDC) number for the prescription. The pharmacist can provide you with this information. You can call the Claims Administrator Customer Service Center number on the back of your Prescription Drug Identification Card, or call the CBS Benefits Contact Center at (877) 377-4357, to request a paper claim form.

### **90-day Supply Retail via CVS and Walgreens**

You can save money on your long-term or maintenance medications by filling at CVS or Walgreens. You pay a lower Copay for a 90-day supply through CVS or Walgreens than for three separate 34-day fills at a retail pharmacy (see the **PRESCRIPTION DRUG SCHEDULE OF BENEFITS** section).

### **90-day via Mail Order Program**

You can also save money on your long-term or maintenance medications by filling through the Mail Order program. Mail Order is delivered within 10 to 14 days and there are no shipping costs. You will receive a mail order form with your new Prescription Drug Identification Card. Contact the toll-free customer service number on the back of your Medical/Prescription Drug Identification Card to learn how to get started using the Mail Order Service. Mail order drugs can also be ordered by calling the number on your Medical/Prescription Drug Identification Card or visiting the Claims Administrator's Web site.

To use your Mail Order Service, you will need to:

- obtain an original prescription from your doctor, written for up to a 90 day supply of medication with appropriate number of refills (up to one year);
- complete the Claims Administrator's order form and Health, Allergy & Medication Questionnaire (the Health, Allergy & Medication Questionnaire was included with your Prescription Drug Welcome Kit, or you can order one from customer service); and
- send your completed Health, Allergy & Medication Questionnaire, order form and original prescription and payment (check or credit card) to the Claims Administrator at the address on the order form.

## Mail Order Reminder

Any time you begin a new maintenance Prescription Drug, have your doctor complete two prescriptions – one to be filled immediately at an in-network retail pharmacy for up to a 34-day supply and the other to be submitted to the Claims Administrator for up to a 90-day supply.

## Specialty Pharmacy Program

The specialty pharmacy program is for Members who use specialty medication to treat a chronic illness, such as multiple sclerosis or rheumatoid arthritis. All maintenance specialty prescriptions is filled at Accredo with no retail courtesy prescriptions. This summary lists your responsibility for covered Prescription Drugs under the specialty pharmacy program.

Manufacturer-funded patient assistance for widely distributed specialty drugs will not be considered as true out-of-pocket for members and may not apply to deductible and out-of-pocket maximums

## Specialty Pharmacy Schedule of Benefits

The following summary lists your responsibility for Specialty Pharmacy Drugs under the Prescription Drug program.

Plan Feature	In-Network Coverage	Out-of-Network Coverage
Specialty Drugs (30-day supply)	You pay \$60 copay	None

## Online Access to the Claims Administrator

Visit the Claims Administrator's Web site 24 hours a day, 365 days a year for the following services and information:

- copayments;
- mail order prescription;
- list of in-network Pharmacies;
- look up whether a particular drug is a Generic or preferred Brand Name Drug;
- look up whether Precertification is required (see the **PRIOR AUTHORIZATION** section); and
- information on specific drugs and health care conditions

## Covered Drugs and Plan Limitations

The Prescription Drug program pays benefits for most FDA-approved medications when you have a valid prescription. Some drugs also require Precertification from the Claims Administrator. For information on whether a specific Prescription Drug is covered by the Plan, call the Claims Administrator customer service number (see the **CONTACTS** section).

## **Generic, Preferred Brand and Non-Preferred Brand Name Drugs**

A Generic Drug is the chemical name of a particular medicine. A Brand Name Drug is the trade name by which it is advertised and sold. Generic Drugs are sold under generic, often unfamiliar, names, yet they have the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand name counterparts.

In general, Generic Drugs cost less than Brand Name Drugs, and preferred Brand Name Drugs cost less than non-preferred Brand Name Drugs. To reduce the cost both to you and to the Company, you should ask your doctor to prescribe Generic Drugs or preferred Brand Name Drugs, whenever possible.

Important Note: Additional criteria may apply to determine whether specific drugs are covered and in what amount or dosage. Please call the Claims Administrator if you have questions about coverage, quantity/dosage limitations or if Precertification is required for a specific drug.

## **Drugs Not Covered**

These products are not covered by the Pharmacy Program:

- any over-the-counter (OTC) medication or OTC equivalent products;
- drugs not approved by the FDA regardless of whether they are prescribed by a physician;
- compounded medications
- Mifeprex
- Blood or blood plasma products
- Blood glucose monitors
- Contraceptive devices
- prescription multiple vitamins (including vitamins with fluoride);
- injectable vitamins;
- hair growth and hair removing products (Rogaine, Propecia, Vaniqa);
- anti-wrinkle products (Renova);
- nutritional supplements; and
- ostomy supplies

Certain items, such as blood glucose monitors, contraceptive devices, and ostomy supplies, may be covered by the medical plan, rather than the pharmacy program. Coverage can be verified by contacting Anthem Blue Cross Blue Shield.

You should also check the **RESTRICTIONS AND EXCLUSIONS** section because those restrictions and exclusions also apply to the Prescription Drug program under the Plan.

## **Drugs Requiring Precertification**

These products are covered by the Plan if you meet the coverage criteria and Precertification is obtained:

- ADHD Therapy – Stimulants and Amphetamines;
- Anti-convulsant Lyrica;
- Infertility treatment;
- Growth Hormones;
- Pain Management Therapy including Oxycontin, Lidoderm, Stadol NS, Actiq, Fentora, Opana ER; and
- all Specialty classified drugs.

## **Exceptions**

The following drugs are covered, with limitations:

- smoking cessation products requiring a prescription (up to a 180 day supply per year)
- Erectile Dysfunction Therapy (Maximum Quantity of 6 for a 34 day supply or 18 for a 90 day supply);
- Migraine Therapy (contact Claims Administrator for drug-specific limitations);
- Retin-A and other similarly classified topical acne drugs covered up to age 21; review all usage cases over the age of 21 with clinical PA for medical necessity; and
- Injectable medications (contact the Claims Administrator for more information).

## **Quantity Limits**

The Company has adopted the Claims Administrator's standard quantity level limit for all other medications

## **Out of Pocket Protection Program**

The Out of Pocket Protection Program minimizes the impact of copayment assistance on plan design, while ensuring members have access to the medications they need. This program adjusts copayment assistance from members' accumulated deductible and out-of-pocket maximum to reflect only what members themselves pay. Funds paid by copay assistance programs will not be applied to the year-to-date accumulators.



# Vision

## Schedule of Benefits

The plan provides coverage for a comprehensive eye exam for each member every 12 months. If you choose to have your exam conducted by an in-network provider, the service will be covered in full with no out of pocket costs at the time of your service. If you chose to have your exam conducted by an out-of-network provider, the plan will reimburse you up to the amount shown in the out-of-network column below.

This schedule of benefits lists the maximum amount the Plan will pay for specific services, called an allowance. The difference between the allowance and the actual charge is your responsibility. The allowance is not subject to the Plan Deductible.

Covered Benefit	Frequency	In-Network	Out-of-Network
<b>Comprehensive Eye Exam</b> (including dilation if needed)	Once every 12 months	Covered in Full	Reimbursable up to \$100
<b>Eyeglass Frames</b>	Once every calendar year	\$150 allowance, then 20% off any remaining balance	\$150 allowance, then 20% off any remaining balance
<b>Eyeglass Lenses</b> (instead of contact lenses). One pair of standard plastic prescription lenses: <ul style="list-style-type: none"> <li>• Single vision lenses</li> <li>• Bifocal lenses</li> <li>• Trifocal lenses</li> </ul>	Once every calendar year	\$20 copay \$20 copay \$20 copay	Up to \$40 reimbursement Up to \$60 reimbursement Up to \$80 reimbursement
<b>Eyeglass Lens Enhancements</b> <ul style="list-style-type: none"> <li>• Transitions Lenses</li> <li>• Standard polycarbonate</li> <li>• Other coatings and treatments</li> </ul>	Once every calendar year	\$75 Adult/\$0 Child \$40 Adult/\$0 Child Varies	No allowance when obtained out-of-network
<b>Contact Lenses</b> (instead of eyeglass lenses) <ul style="list-style-type: none"> <li>• Elective conventions (non-disposable)</li> </ul> <u>OR</u> <ul style="list-style-type: none"> <li>• Elective disposable</li> </ul> <u>OR</u> <ul style="list-style-type: none"> <li>• Non-elective (medically necessary)</li> </ul>		\$150 allowance, then 15% off balance  \$150 allowance (no additional discount)  Covered in full	Up to \$105 reimbursement  Up to \$105 reimbursement  Up to \$210 reimbursement

## Eye Examination

An eye examination includes:

- a complete case history;
- external examination of the eye and ednexa;
- ophthalmoscopic examination;
- binocular balance testing;

- tonometry test for glaucoma, when indicated;
- gross visual fields, when indicated;
- color vision testing, when indicated;
- summary finding; and
- recommendations or prescribing corrective lenses.

## **Filing a Claim**

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### **How to File a Claim**

You do not have to submit a claim form for services provided In-Network. Payment will be sent directly to your Provider. If you go to an Out-of-Network Provider, you need to submit a claim form to the Claims Administrator. Be sure to file a separate claim for each member of your family. Make copies of all itemized bills.

You can get a claim form from the CBS Benefits Contact Center or the My Wellbeing site at [www.mywellbeing@cummins.com](http://www.mywellbeing@cummins.com). See the **CONTACTS** section.

### **Deadline for Filing Claims**

Generally, you should file claims within 90 days of the date of service. However, there is a claim filing deadline that you need to note. You must file your claim by the end of the calendar year after the calendar year in which the service was rendered. If you do not submit the claim by the end of the calendar year after the calendar year in which the service was rendered, benefits for that health service will be denied.

### **Claim Recap (formerly “Explanation of Benefits”)**

You will receive a detailed statement called a claim recap. The claim recap will explain what amounts have been paid and what amounts have not been paid. The statement will explain the reason why a claim has not been paid.

### **If A Claim Is Denied**

#### **Review of claims**

The Plan will review your claim or your Dependent’s claim for benefits in accordance with the following procedures. If you believe that you are entitled to a benefit that has not been provided or to a greater or different benefit than has been provided, or you disagree with any other action taken by the Claims Administrator, the Plan also provides appeals procedures.

During the review and appeal procedures, the Claims Administrator or its designee shall have the right and opportunity to have a Physician, who is chosen by the Claims Administrator or its designee, examine any Member whose injury or sickness is the basis of the claim. The Claims Administrator or its designee shall also have the right and opportunity to have a second Physician, who is chosen by the Claims Administrator or its designee, examine any Member with regard to any injury or sickness which is the

basis of a claim. If the opinion of the second Physician differs from the opinion of the first Physician, the Claims Administrator or its designee may follow the opinion of the second Physician. The costs of any physical examination required under this provision shall be paid by the Plan or the Company. Further, the Claims Administrator or its designee shall have the right to orally question the Physician, health care provider, or other professional person whose services are covered by the Plan and whose course of treatment is the basis of the claim. These rights shall be exercisable by the Claims Administrator or its designee as often as is reasonably necessary during the review and appeal process.

### **Pre-Service Claims**

A "pre-service claim" is any claim for a benefit under the Plan for which the Plan requires you to obtain approval of the benefit before receiving medical care. In other words, if the Plan requires Precertification (see the **PRECERTIFICATION** section) then the claim is a pre-service claim. If you file a claim for pre-service approval with the Claims Administrator, and you do not properly identify yourself, specify the medical condition or symptom, and the specific treatment, service, or product for which approval is requested, the Claims Administrator will notify you of your failure and the proper procedures to be followed in filing a claim, within 5 days. The notification may be oral, unless you request a notice in writing.

Upon filing a pre-service claim, the Claims Administrator will notify you of its decision within 15 days of receipt of your claim. This 15-day period may be extended for an additional 15 days if the Claims Administrator (a) determines that an extension is necessary due to matters beyond the Plan's control, and (b) notifies you of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If an extension is necessary because you have not submitted all the information necessary to decide your claim, the notice of extension will specifically describe the additional information required, and you will have at least 45 days to provide the requested information. If you deliver the information within the time specified, the 15 day extension period will begin after you provide the information. Any notice you receive regarding an adverse decision on your claim will include the information described in the paragraph below entitled **NOTICE OF ADVERSE DECISIONS**.

### **Concurrent Care Decisions**

If the Plan has approved an ongoing course of treatment to be provided over a period of time or for a certain number of treatments, the following will apply:

- If the Plan reduces or terminates the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments, you will be notified sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of the Plan's decision before it becomes effective.
- In a case involving a claim for urgent care, you may request the Plan to extend the course of treatment beyond the already approved time or number of treatments. The Claims Administrator will notify you of its decision within 24

hours of its receipt of your request, provided that you make your request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claims Administrator denies your claim, you will receive notification of the denial.

### **Post-Service Claims**

If you file a claim for a benefit that relates to a service that has already been provided, the Claims Administrator will notify you whether your claim is approved or denied within 30 days after receipt of the claim. The Claims Administrator may extend this period by up to 15 days if it (a) determines that the extension is necessary due to matters outside of the Plan's control, and (b) the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary because you did not submit all the information necessary to decide the claim, the notice of extension will specifically describe the additional information required. You will have at least 45 days to provide the requested information. If you deliver the information within the time specified, the 15 day extension period for the Claims Administrator to decide your claim will begin after you provide the information. Any notice you receive regarding an adverse decision on your claim will include the information described in the paragraph below entitled **NOTICE OF ADVERSE DECISIONS**.

### **Urgent Care**

A claim is an "urgent care claim" if processing the claim within the Plan's normal time frames: (a) could seriously jeopardize your life, health, or ability to regain maximum function; or (b) in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment requested in your claim.

The following procedures will apply to any urgent care claim:

- The Claims Administrator will notify you of its determination as soon as possible, taking into account the medical circumstances, but no later than 72 hours after it receives your claim.
- If you file a claim for urgent care with the Claims Administrator, and you do not properly identify yourself, specify the medical condition or symptom, and the specific treatment, service, or product for which approval is requested, the Claims Administrator will notify you of your failure and the proper procedures to be followed in filing a claim, within 24 hours. The notification may be oral, unless you request a notice in writing. You will have at least 48 hours in which to provide the additional information. The Claims Administrator will notify you of its decision within 48 hours after it receives the additional information, or, if you do not provide the requested information, 48 hours after the end of the period of time that you were given to provide the information.
- If the Claims Administrator denies your claim, you will receive written notification of the denial. Any notice you receive regarding an adverse decision on your claim will include the information described in the paragraph below entitled **NOTICE OF ADVERSE DECISIONS**.

## Notice of Adverse Decisions

If your claim for benefits is wholly or partially denied, the Claims Administrator will notify you, in writing, and the notice will include the following:

- the specific reason or reasons for denial of the claim;
- reference to specific Plan provisions on which the denial is based;
- a description of any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that the information will be provided free of charge upon request);
- if the denial is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, an explanation of any scientific or clinical judgment on which the denial is based (or a statement that the explanation will be provided free of charge upon request);
- a description of any additional material or information that you may need to provide with respect to the claim, with an explanation as to why the material or information is necessary; and
- an explanation of your right to appeal the claim denial under the Plan's review procedures, including expedited review of claims involving urgent care, and your right to bring a civil action in federal court following any further denial of your claim on review.

In the case of a claim involving urgent care, the Claims Administrator may provide the above information by telephone, facsimile or similar method, and if provided to you orally, a written or electronic notification will be furnished to you within 3 days after the oral notification. Notice must be provided even if the claims is approved.

## Benefits Complaint and Appeals Procedure

The Plan wants your experience to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your Identification Card. You should note that there are different Claims Administrators for Medical and Prescription Drug claims. Their individual contact information can be found at the end of this document in the **CONTACTS** section. The Claims Administrator will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file an appeal, which is defined as follows:

For purposes of these appeal provisions, "claims 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.

\*A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect. Coverage may be rescinded only if you commit fraud or make an intentional misrepresentation of material fact. For example, if an Employee knowingly enrolls a person as a Spouse when the Employee had not married the person (perhaps by submitting a fraudulent marriage license), coverage may be rescinded. You will be provided at least 30 days' advance written notice if you would be affected before coverage may be rescinded.

### **Notice of Adverse Benefit Determination**

If your claim is denied, the Claims Administrator's notice of 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 this Plan is subject to ERISA, within one year of the grievance or appeal decision if you submit a grievance or 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;
- 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; and,
- information regarding your potential right to an External Appeal pursuant to Federal law.
- 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.).
- In accordance with reasonable claims procedures, the Plan may require your authorized representative to be designated in writing on a form provided by the Claims Administrator or Plan Administrator.

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 you or your 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 or 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."

If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with your claim, the Claims Administrator will provide you with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

## **Voluntary Second Level Appeals**

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal is 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, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to Federal law.

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

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

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 one year 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.

## **Coordination of Benefits**

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If you or a covered Dependent is covered by another medical plan, this Plan has a coordination of benefits feature to prevent duplication of benefit payments.

Coordination of benefits allow the plans to work together to cover eligible expenses. The plan that has the first obligation to pay is called the "primary plan;" the other plan is called the "secondary plan." Typically, a secondary plan will pay when its benefit is more generous.

A Member may be covered as a Dependent under two or more plans. Certain rules govern which plan is primary and which is secondary. Those rules follow this order (use the first rule that applies and disregard the rest of the rules):

- No Coordination Rules: a plan that has no coordination of benefits provision will be primary to a plan that does have a coordination of benefits provision;
- Non-Dependent/Dependent: a plan that covers a participant as an employee, retiree, or primary member (or in any other capacity *other than* a dependent) will be primary to a plan that covers the person as a dependent; provided however, if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is: secondary to the Plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order is reversed so that the plan covering the person as an employee, retiree, or primary member is secondary and the other plan is primary;
- Dependent Child/Parents Not Separated or Divorced, or Divorced Sharing Expenses: unless there is a court decree stating otherwise, when two plans cover a dependent child whose parents are married or are living together (regardless of whether they have ever been married), or who are divorced or separated but who share responsibility for the dependent's health care expenses, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan, but if both parents have the same birthday, the plan covering the parent for the longest time is considered the primary plan. However, if the other plan does not have the foregoing rule, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
- Dependent Child/Separated or Divorced Parents: when two plans cover a dependent child whose parents are divorced or separated or are not living together (regardless of whether they have ever been married), the following rules apply:
  - if there is a court decree giving one parent financial responsibility for the medical, dental or other health expenses of the dependent child, that parent's plan will be primary (and if that parent does not have coverage, but that parent's spouse does, that parent's spouse's plan is the primary plan);
  - if there is no court decree or if the court decree does not allocate responsibility for the dependent child's health care expenses, then the order of benefits for the child is: (a) the plan covering the custodial parent; (b) the plan covering the custodial parent's spouse; (c) the plan covering the non-custodial parent; and then (d) the plan covering the non-custodial parent's spouse.
- Active/Inactive Employee: the benefits of a plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan that covers that person as a laid-off or retired person (or that person's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is

ignored. This rule does *not* supersede the Non-Dependent/Dependent rule above;

- Continuation Coverage: if a person, whose coverage is provided under a right of continuation coverage under federal or state law, is also covered by another plan, the benefits of the plan that covered the person as an employee (or as the employee's dependent) shall be determined first and the benefits under the continuation coverage shall be determined second.
- Longer/Shorter Length of Coverage: if none of the above rules determines the order of benefits, the benefits of the plan that covered an employee longer are determined before those of the plan that covered the employee for a shorter time.

Under coordination of benefits, if the Plan is the secondary payer, the Plan will determine what benefits it would have paid if you did not have other coverage, and then deduct the amount paid by the other plan. If the other plan pays more than the Plan would normally pay, then the Plan will not pay any additional benefits. If the other plan pays less than the Plan would pay, then the Plan will pay the difference up to its normal benefit.

### **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 was a benefit paid under this Plan and 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 reasonable cash value of the benefits provided in the form of services.

### **Coordination with Medicare**

Any benefits covered under both this Plan and Medicare will be paid according to Medicare Secondary Payor laws and regulations. This Plan may be amended to accommodate changes in Medicare eligibility or benefits. To the extent allowed under Medicare Secondary Payor laws and regulations, this Plan will be secondary to coverage under Medicare. The benefit payable under this Plan shall be reduced by the greater of: (a) the amount actually paid by Medicare; or (b) the amount Medicare would pay if the Member was eligible for Medicare and was enrolled in Medicare (even if the Member was not actually enrolled). If required by law, this Plan will be primary to Medicare and this Plan shall pay for Covered Expenses as set forth in the Plan. Where Medicare is the primary payor, all sums paid by Medicare for services provided to Members shall be reimbursed by or on behalf of the Member to the Plan, to the extent the Plan has made payment for such services.

### **Coordination with Worker's Compensation**

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. This Plan shall be secondary to any such benefits. All sums paid or payable by Worker's 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 Worker's Compensation.

### **Coordination with Other Government Programs**

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

## **Subrogation and Right of Reimbursement**

These provisions apply when Plan benefits are paid as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery.

### **Subrogation and Reimbursement**

The Claims Administrator or the Company has the right to recover Plan payments made on your behalf from any party responsible for compensating you for your injuries through a Recovery. The Plan's subrogation and reimbursement rights apply if a Member receives, or has the right to receive, any sum of money through a Recovery, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan or legal entity that is legally obligated to make payments as a result of a judgment, settlement, or otherwise, arising out of any act or omission of any third party (whether a third party or another Member under the Plan): (a) who is allegedly wholly or partially liable for costs or expenses incurred by the Member, in connection for which the Plan provided benefits to, or on behalf of, such Member; or (b) whose act or omission allegedly caused injury or sickness to the Member, in connection for which the Plan provided benefits to, or on behalf of, such Member.

For example, if you are in a car accident, sue the other driver, and recover money for your medical expenses, you will have to pay that money back to the Plan if the Plan already paid for your medical expenses. The following rules apply. These rules may be modified to the extent necessary to comply with applicable law.

- By participating in the Plan, you and your Dependents agree that the Plan is subrogated to all of your and your Dependents' rights, and you acknowledge that the Plan will have a lien against any sum of money received from a third party or its insurers or the insurer of a Member.
- In the event a Member settles with, recovers from, or is reimbursed by any third party, the Member shall agree to hold any such funds received in trust for the benefit of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of the Member's injury or condition.
- The Plan has the first priority for the full amount of benefits it has paid from any recovery regardless of whether the Member is fully compensated, and regardless of whether the payments the Member receives make the Member whole for the

Member's losses, injuries, damages, loss, or debt. The Plan expressly repudiates the "make whole" doctrine and all other legal or equitable concepts that reduce the Plan's subrogation/reimbursement rights. The Plan's rights shall continue until the Member's obligations to the Plan are fully discharged. This right to subrogation *pro tanto* shall exist in all cases. The Plan's right is a first priority lien, and the Plan's subrogation and reimbursement rights shall be first satisfied before any part of a Recovery is applied to a Member's claim, attorney fees, other expenses, or costs

- If a Member fails or refuses to comply with these provisions, the Plan has the right to impose a constructive trust over any and all funds the Member receives or has the right to receive. The Plan has the authority to pursue any and all legal and equitable relief available to enforce the rights against any and all appropriate parties who may be in possession of the funds.
- The Plan is not responsible for any attorney fees, other expenses, or costs without its prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney hired by a Member regardless of whether funds recovered are used to repay benefits paid by the Plan.
- The Plan, through the Plan Administrator, has full discretionary authority to construe and interpret these provisions and to determine all questions of fact and law arising hereunder. It will be within the discretionary authority of the Plan Administrator to resolve, settle, or otherwise compromise its subrogation and reimbursement rights when appropriate. The Plan Administrator is under no obligation to reduce its lien or reimbursement rights unless, in its sole discretion, it determines that doing so is appropriate.
- If the Member or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party or any other persons to obtain a judgment, settlement or other Recovery, the Plan Administrator or its designee, upon giving 30 days' written notice to the Member, shall have the right to take such action in the name of the Member to recover that amount of benefits paid under the Plan; provided, however, that any such action taken without the consent of the Member shall be without prejudice to such Member.
- The Plan may withhold payment of benefits for an injury or illness when a party other than the Member or the Plan may be liable for expenses for that injury or illness until liability is legally determined. In the event that any payment is made under the Plan for which any party other than the Member or the Plan may be liable, the Plan shall be subrogated to all rights of recovery of the Member to the extent of payments by the Plan and shall have the right to be reimbursed.
- If the Member receives any sum of money described in this **SUBROGATION AND REIMBURSEMENT** section, the Plan shall have no further obligation to pay benefits relating in any way to future claims for the same or related injuries or illnesses, including but not limited to any complications thereof, for which the Member received such sum of money, and Covered Expenses incurred for such future claims shall be excluded.

## Your Duties

- You must notify the Claims Administrator 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 and any legal representatives must do whatever is necessary to enable the Plan to exercise its rights and do nothing to prejudice them. You shall not discharge or release any party from any alleged obligation to you or take any other action that could impair the Plan's rights to subrogation or reimbursement without the written authorization of a Plan representative. Upon request, a Member shall execute and return a subrogation agreement to the Plan and will supply other reasonable information and assistance as requested by the Plan regarding the claim or potential claim. If the subrogation agreement is not executed and returned or if information and assistance is not provided to the Plan upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such illness or injury.
- You must cooperate with the Plan in the investigation, settlement, and protection of the Plan's rights;
- You must send the Claims Administrator copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you; and
- You must promptly notify the Claims Administrator if you retain an attorney or if a lawsuit is filed on your behalf.

## Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover the payment from you or any other appropriate person or entity, including the Provider, whether or not the payment error was made due to the Company's, Plan Administrator's, Claims Administrator's, or Plan's own error. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

If the amount of the payments made by this Plan is more than should have been paid under this **SUBROGATION AND RIGHT OF REIMBURSEMENT** provision, this Plan may recover the excess from one or more of:

- the persons it has paid or for whom it has paid;
- another plan; or
- the Provider of service.

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

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## Termination and Continuation

Subject to COBRA, if you cease to meet eligibility requirements as outlined in this Plan, your benefits will terminate automatically at midnight of the last day you meet the Plan's

eligibility requirements as described in the **ELIGIBILITY** section of this Plan. You shall notify the Claims Administrator and/or the Company immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

If a Member engages in fraudulent conduct or furnishes the Company or Claims Administrator fraudulent or misleading material information relating to claims or application for benefits, then the Company may terminate that Member's benefits. Termination is effective on the date of the fraudulent conduct or furnishing of fraudulent or misleading material information, whichever is applicable. You shall be responsible to pay the Company for the cost of previously received services based on the Reasonable Charges for such services, less any Copayments made or fees paid for such services. The Company will also terminate your Dependent's benefits, effective on the date your benefits were terminated, if you were the Member who engaged in the fraud or furnishing of fraudulent or misleading material information.

If you permit the use of your or any other Member's Identification Card by any other person, use another person's card, or use an invalid card to obtain services, your coverage shall terminate immediately. Any Member involved in the misuse of an Identification Card will be liable to and must reimburse the Company for the Reasonable Charges for services received through such misuse.

If you fail to pay or fail to make satisfactory arrangements to pay any amount due to the Company or any Provider (including the failure to pay required Deductibles and/or Copayments), the Company may terminate your rights and may also terminate the rights of all your eligible Dependents, effective immediately.

A Dependent's benefits terminate on the date that person no longer meets the definition of Dependent.

## **COBRA**

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This section is intended to comply with COBRA, which requires continuation of medical coverage to certain Members whose coverage would otherwise terminate. If this section is incomplete or in conflict with the law, the terms of the law will govern.

### **Continuation of Coverage**

You and your covered Dependents may continue your current medical coverage if it ends because of one of the following "qualifying events:"

- layoff;
- you voluntarily leave the Company;
- the Company ends your employment for any reason (including benefits terminating after you have been on Disability for 2 years), unless you were fired because for gross misconduct; or
- the number of hours you are scheduled to work are reduced below those required for you to be eligible for benefits.



COBRA coverage also is available to your covered Dependents if their coverage would otherwise end because of one of the following "qualifying events:"

- layoff;
- you voluntarily leave the Company;
- the Company ends your employment for any reason (including benefits terminating after you have been on Disability for 2 years), unless you were fired because for gross misconduct;
- the number of hours you are scheduled to work are reduced below those required for you to be eligible for benefits;
- your death;
- your divorce, legal separation or annulment of your marriage;
- Medicare entitlement;
- your Dependent child becomes ineligible for coverage; or
- your Dependent no longer qualifies as a covered Dependent

Only "qualified beneficiaries" may elect continuation coverage under the Plan. For purposes of the medical, Prescription Drug, and vision benefits of the Plan, a "qualified beneficiary" means you if you are an individual who, on the day before a qualifying event, is a Covered Employee or an eligible Dependent under the medical, Prescription Drug, and/or vision benefits. Such term will also include a child who is born to or placed for adoption with the Covered Employee during the period of continuation coverage.

COBRA coverage continues for up to 18, 29 or 36 months, depending on the qualifying event. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars.

If you are disabled as determined by the Social Security Administration, you may elect to continue COBRA for up to 29 months but pay 102% of the cost for coverage for the first 18 months, and 150% for the remaining 11 months.

Premiums are due monthly and are made on an after-tax basis. If COBRA continuation coverage is elected after a qualifying event has occurred, a qualified beneficiary will be permitted, for a period of 45 days after the date of his or her election of continuation coverage, to pay the premium required under the Plan for continuation coverage during the period preceding his or her election. **Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due.** Payment of any premium (other than the initial one – described above) will be considered "timely" only if it is made within 30 days after the due date. **It is your responsibility to pay the premium on time. If the Plan provides you with payment reminders or payment coupons, but later ceases to do so, it still remains your responsibility to make the premium payments on time even if you no longer receive the payment reminders or coupons.**

Length of COBRA coverage	Qualifying Event
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18 months (for Employee and Dependents)	You resign You transfer to part-time or limited-hour status Your employment ends for a reason other than gross misconduct The last day of FMLA if you fail to return to Active Work
29 months (for Employee and Dependents)	The Social Security Administration determines that you or your Dependent was permanently disabled at any time within the first 60 days of continuation coverage.
36 months (for Dependents)	Your divorce, annulment or legal separation from your Spouse Your death Your Dependent child becomes ineligible for coverage (in this case, your child would be eligible for COBRA, but your coverage under the Plan would not change) Your Medicare entitlement
36 months (for Domestic Partner)	You and your Domestic Partner terminate your relationship.

If you are already covered by COBRA under the 18 month provision, and any of the qualifying events in the immediately preceding table occur, your Dependents can extend coverage to a maximum of 36 months from the date of the original qualifying event. This second qualifying event will not act to extend coverage beyond the original 18 month period for any Dependents (other than a newborn or newly adopted child) who were added after the date continuation coverage began.

If you become entitled to Medicare and then within 18 months experience a termination of employment or reduction in hours, qualified beneficiaries other than you may elect to extend coverage for up to 36 months from the date you became entitled to Medicare.

If you elect COBRA coverage and the Social Security Administration determines that a qualified beneficiary was disabled at any time within the first 60 days of the date of the initial continuation coverage, the following applies:

- all qualified beneficiaries whose coverage is due to the same qualifying event may elect to extend coverage for up to 29 months from the date of the original qualifying event. To obtain this extended coverage, the qualified beneficiary must notify the COBRA Administrator of the disability determination within 18 months of the qualifying event **and** within 60 days after the latest of: (a) the date

the qualified beneficiary is determined to be disabled by the Social Security Administration, (b) the date the qualifying event occurs, (c) the date the qualified beneficiary loses or would lose coverage, or (d) the date the qualified beneficiary is notified of his or her notice obligation; and

- the qualified beneficiary must notify the COBRA Administrator within 30 days of the later of: (a) the date of final determination by the Social Security Administration that the qualified beneficiary is no longer disabled, or (b) the date the qualified beneficiary is notified of his or her notice obligation.

## Electing COBRA

You and your covered Dependents will receive election forms and more information about COBRA from the CBS Benefits Contact Center (the COBRA Administrator). If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your coverage ends as a result of a qualifying event, or 60 days after the date of the notice of COBRA rights and your election is mailed to you, whichever is later. You must pay any cost necessary to avoid a gap in coverage within 45 days of the date you elect COBRA. Each qualified beneficiary who loses coverage as a result of a qualifying event shall have an independent right to elect continuation coverage, regardless of whether any other qualified beneficiary with respect to the same qualifying event elects continuation coverage.

## Required Notices

### Qualified Beneficiary Notification to Plan Administrator

**COBRA requires you or your covered Dependent(s) to notify the COBRA Administrator about events affecting the right to continuation coverage.** Here's a summary of your notification requirements when you or your Dependents' coverage would otherwise end:

When These Events Occur:	You Must Notify the Plan Administrator:
your marital status changes, one of your Dependents no longer qualifies for Dependent coverage, or a second qualifying event occurs during the initial 18-month COBRA continuation coverage period.	within 60 days after the later of: (a) the date of the event, (b) the date you or your Dependent would lose coverage due to the event, or (c) the date you are notified of your notice obligation.
you or a Dependent are determined to be eligible for Social Security disability benefits (at the time of termination of employment or reduction in hours or within 60 days of the date employment terminates or hours are reduced).	within the first 18 months of your continuation coverage and within 60 days after the latest of: (a) the date you or your Dependent are determined to be disabled by the Social Security Administration, (b) the date the qualifying event occurs, (c) the date you or your Dependent lose or would lose cover-

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age, or (d) the date you or your Dependent are notified of your notice obligation.

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if Social Security determines you or a Dependent are no longer disabled.

within 30 days of the later of: (a) the date of final determination by the Social Security Administration that you or your Dependent are no longer disabled, or (b) the date you or your Dependent are notified of your notice obligation.

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***If you do not provide notice within the specified time period, continuation coverage will not be available to you or your Dependents.***

### **General Notification to Employee and Spouse**

The Company will give written notice to you and your Spouse of your rights to continuation coverage. This notice will be provided to you and your Spouse not later than the earlier of: (a) 90 days after your coverage begins, or (b) the date you would otherwise receive an election form due to a qualifying event (see COBRA Administrator Notification to Qualified Beneficiary below).

### **Company Notification to COBRA Administrator**

The Company will notify the COBRA Administrator in the event of an Employee's death, employment termination, reduction in hours of employment, or entitlement to Medicare benefits, within 30 days after the date of the qualifying event.

### **COBRA Administrator Notification to Qualified Beneficiary**

- Within 14 days after receiving a notice from you under the rules outlined above, or within 14 days after receiving a notice from the Company about your employment termination, reduction in hours, disability, death, or entitlement to Medicare, the COBRA Administrator will notify you and/or your eligible Dependents of your right to elect continuation coverage. You and/or your Dependents will have 60 days to elect continuation coverage from the later of the date the notice is sent to you or the date you would lose coverage. Your initial payment for continuation coverage is required within 45 days of the date such coverage is elected and will be in an amount sufficient to pay for all months of coverage between the date of the qualifying event and the date payment is made.
- In addition, if you or another qualified beneficiary are not entitled to receive continuation coverage, you or the qualified beneficiary will be notified of this and will be provided with an explanation as to why you or the qualified beneficiary are not entitled to this continuation coverage.
- Finally, the COBRA Administrator will provide notice to each qualified beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum period of continuation coverage applicable to such qualifying

event, as soon as practicable following the COBRA Administrator's determination that continuation coverage should terminate.

In general, the COBRA Administrator's notices to qualified beneficiaries must be provided to each qualified beneficiary; however (a) a single notice can be provided to the Employee and the Employee's Spouse or Domestic Partner (as applicable) if the Spouse or Domestic Partner resides with the Employee, and/or (b) a single notice can be provided to the Employee or the Employee's Spouse or Domestic Partner for a Dependent child of the Employee, if the Dependent child resides with the Employee, the Spouse (as applicable), or Domestic Partner.

### **When COBRA Ends**

COBRA coverage ends when one of the following events occurs:

- the COBRA period (18, 29, or 36 months) ends;
- premiums are not paid on a timely basis;
- the Company stops offering any group health plan;
- the person who elected COBRA becomes covered under another group medical plan as an employee or otherwise and is not affected by any Pre-Existing Condition prohibitions or limitations in such plan;
- the person who elected COBRA first becomes entitled to Medicare after COBRA coverage was elected; or
- the person who elected COBRA ceases to be disabled if continuation coverage is due to a disability.

In addition, the Plan may also terminate the continuation coverage of a qualified beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (e.g., in the case of submitting fraudulent claims to the Plan).

### **COBRA Continuation Coverage Provided**

The COBRA continuation coverage provided is identical to the coverage provided to similarly situated members covered by the Plan with respect to whom a qualifying event has not occurred. If coverage is changed under the Plan for any group of similarly situated covered members, coverage will also be modified for all qualified beneficiaries. Evidence of good health is not required for COBRA continuation coverage. During the Plan's open enrollment period during which similarly situated active employees may choose to be covered under another group health plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to qualified beneficiaries who have elected continuation coverage.

# **USERRA Rights and Coverage**

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## **USERRA Continuation Coverage**

If a Covered Employee is absent from a position of employment with the Company by reason of Service in the Uniformed Services and was covered under the Plan immediately prior to his or her absence due to Service in the Uniformed Services, such Covered Employee and his or her eligible covered Dependents shall be entitled to elect to continue health care coverage under the Plan for a period equal to the lesser of (a) the 24 month period beginning on the date on which such Covered Employee is absent from employment with the Company by reason of Service in the Uniformed Services or (b) the day following the date on which the Covered Employee fails to apply for or return to a position of employment with the Company as determined pursuant to USERRA Section 4312(e). Covered Employees may elect to discontinue coverage under the Plan during Service in the Uniformed Services by submitting the applicable forms to the Company.

## **Election of USERRA**

Continuation coverage does not begin unless it is elected by the Covered Employee. The Covered Employee may elect to continue coverage by reason of Service in the Uniformed Services for himself and his covered Dependents. (Dependents do not have an independent right to elect USERRA continuation coverage.) The election period for continued coverage shall begin on the date the Covered Employee gives the Company advance notice that he is required to report for Uniformed Service (whether such service is voluntary or involuntary) and shall end 60 days after the date the Covered Employee would lose coverage under the Plan.

If the Covered Employee is unable to give advance notice of Uniformed Service, the Covered Employee may still be able to elect continuation coverage under this Article if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such case, the election period shall begin on the date the Covered Employee leaves for Uniformed Service and shall end on the earlier of: (a) the 24 month period beginning on the date on which the Covered Employee's absence for the Uniformed Service begins; or (b) the date on which the Covered Employee fails to return from Uniformed Service or apply for a position of employment as provided under 20 C.F.R. §§ 1002.115-123. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 C.F.R. § 1002.86 and may include situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the Company is unavailable or the Covered Employee is required to report for Uniformed Service in an extremely short period of time.

The election of USERRA continuation coverage must be made on a form provided by the Plan Administrator and made within the 60 day period described herein. An election is considered to be made on the date it is sent to the Plan Administrator. If timely elected pursuant to this Section, coverage shall be reinstated as of the date the eligible

Employee lost coverage due to absence for Service in the Uniformed Service and shall last for the period described above; provided that the eligible Employee pays all unpaid costs for the coverage.

### **Cost of USERRA Continuation Coverage**

If a Covered Employee elects USERRA continuation coverage, such Covered Employee shall be required to pay one hundred two percent (102%) of the full premium cost for such coverage if the Covered Employee's Service in the Uniformed Services lasts longer than 30 days.

Premiums are due on the first day of each month for which continuation coverage is desired. Failure to pay premiums on a timely basis shall result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, shall only be considered to be timely if made within 30 days after the date due. A premium must also be paid for the cost of continuation coverage for the time period between the date that continuation coverage commences and the date continuation coverage is elected. This payment must be made within 45 days after the date of election. Failure to pay this premium on the date due shall result in cancellation of coverage back to the initial date coverage would have terminated.

### **Coordination with COBRA**

A Covered Employee who is absent from work by reason of Service in the Uniformed Services may be eligible for COBRA continuation coverage as described in the **COBRA** section of this Plan. The USERRA continuation coverage described in this section shall not limit or otherwise interfere with the COBRA continuation coverage rights; provided, however, any USERRA continuation coverage shall run concurrently with any COBRA continuation coverage.

### **Rights, Benefits, and Obligations of Employees Absent from Employment By Reason of Service in the Uniformed Services**

A Covered Employee who is absent from employment with the Company by reason of Service in the Uniformed Services shall be considered on furlough or leave of absence while performing such service and shall be entitled to such other rights and benefits as are generally provided by the Company to employees having similar status and pay who are on furlough or leave of absence; provided, however, a Covered Employee who knowingly provides written notice of intent not to return to employment with the Company shall cease to be entitled to such rights and benefits.

### **USERRA Continuation Health Benefits Provided**

The continuation coverage provided to a Covered Employee serving in the Uniformed Services who elects continued coverage (and his covered Dependents) shall be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan who are active. If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are covered under USERRA continuation coverage. Continuation coverage may not be conditioned on evidence of good health. If the Plan provides an open enrollment period during which similarly situated active employees

may choose to be covered under another group health plan or under another benefit package within the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to individuals who have elected USERRA continuation coverage.

### **Reinstatement of Coverage Upon Reemployment**

The Company shall promptly reinstate Plan coverage when a Covered Employee is reemployed after Service in the Uniformed Service; provided, however, a request to reinstate Plan coverage must be made by the Covered Employee within 31 days of reemployment (presuming the Covered Employee has sought reemployment with the Plan in compliance with 20 C.F.R. Part 1002, Subpart C). If no request is made within this time period, no coverage shall be reinstated under the Plan. A Covered Employee and his or her eligible covered Dependents whose benefit coverage is terminated by reason of Service in the Uniformed Services, shall not be subject to any exclusion or waiting period upon reinstatement of such coverage following Service in the Uniformed Services; provided however, the above shall not apply to any condition determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of Service in the Uniformed Services.

## **Administrative Information**

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The information presented in this Plan is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA).

This Plan supersedes and replaces any past plans or summaries and any verbal or written representations or practices inconsistent with the Plan.

### **Plan Administrator**

The Company shall be the Plan Administrator within the meaning of the ERISA; provided, however, the Company may from time to time designate a person, subcommittee, Claims Administrator, or organization to perform certain responsibilities of the Plan Administrator. Any such individual, subcommittee, or organization shall perform the delegated functions until removal by the Company, which removal may be without cause and without advance notice. Except as otherwise specifically provided in the Plan, the Plan Administrator shall have full, discretionary authority to control and manage the operation and administration of the Plan, and shall be the named fiduciary of the Plan. The Plan Administrator shall have all power necessary or convenient to enable the Plan Administrator to exercise such authority. The Plan Administrator or its designee may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under the Act. The Plan Administrator is authorized to accept service of legal process for the Plan. The Company may appoint a carrier, person, entity or corporation



to provide consulting services to the Company and to the Plan Administrator in connection with the operation of the Plan, and it may perform such other functions and services, including the processing and payment of claims, as may be delegated to it by the Company.

Except as may be otherwise specifically provided in the Plan or in any benefit contract or policy, the Plan Administrator or its designee shall have full, discretionary authority to enable it to carry out its duties under the Plan, including but not limited to, the authority to determine eligibility under the Plan and to construe and interpret the terms of the Plan and to determine all questions of fact or law arising hereunder and to authorize coverage in a manner which is cost effective under the Plan. The Plan Administrator shall also have the authority to delegate its authority to others, including the Claims Administrator. The discretionary authority delegated to any designee shall, however, be limited to Plan terms relevant to its delegated responsibilities and shall not permit the designee to render a determination or make any representation concerning benefits which are not provided by the express terms of the Plan. The designee's actions shall be given full force and effect unless determined by the Plan Administrator to be contrary to the Plan provisions or arbitrary and capricious. All such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby. The Plan Administrator or its designee shall have full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the Plan in such manner and to such extent as it may deem expedient, and the Plan Administrator or its designee shall be the sole and final judge of such expediency. Benefits under this Plan shall be paid only if the Plan Administrator and/or the Claims Administrator decides in his or her discretion that the Covered Person is entitled to such benefits under the Plan.

The Plan Administrator may designate another person or persons to carry out any fiduciary responsibility of the Plan Administrator under the Plan. For example, the Plan Administrator has appointed the Claims Administrator as fiduciary of the Plan for purposes of determining claims and appeals for benefits under the Plan. The Plan Administrator shall not be liable for any act or omission of such person in carrying out such responsibility, except as may be otherwise provided under ERISA. To the extent permitted under ERISA, no fiduciary of the Plan shall be liable for any act or omission in carrying out the fiduciary's responsibilities under the Plan. To the extent permitted under ERISA, each fiduciary under the Plan shall be responsible only for the specific duties assigned under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary.

### **Future of the Plan**

The future of the Plan and future benefits depend upon the future of the Company. The Company hopes to continue providing benefits and every effort has been made to foresee and provide for future benefits. However, the Company reserves the right to change, suspend temporarily, or terminate the Plan. The Executive Committee of the Company shall make any such change by adoption of the appropriate resolutions. To the extent allowed by ERISA, any change, suspension, or termination of the Plan may be effective retroactively.

## **Modifications**

This Plan shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Company without the consent or concurrence of any Member. By electing medical 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.

## **Employer's Sole Discretion**

The Company may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Company, 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.

## **Not Liable for Provider Acts of Omissions**

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

## **Limitation of Rights**

Neither the establishment nor maintenance of the Plan nor any amendment thereof, nor any act or omission under the Plan or resulting from the operation of the Plan shall be construed:

- as conferring upon any Member, beneficiary or any other person a right or claim against the Company or the Plan Administrator, except to the extent that such right or claim shall be specifically expressed and provided in the Plan or provided under ERISA;
- as creating any responsibility or liability of the Company or Plan Administrator for the validity or effect of the Plan;
- as a contract or agreement between the Company and any Member or other person;
- as being consideration for, or an inducement or condition of, employment of any Member or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of the Company or any Member or other person to continue or terminate the employment relationship at any time; or
- as giving any Member or other person, the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Member or other person at any time.

## **Certificate of Creditable Coverage**

If your benefits under the Plan are terminated, you and your covered Dependents will receive a certification that shows the period of time you received benefits under this

health benefit Plan. Your certificate of creditable coverage will show your most recent period of continuous coverage under the 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.

### **Newborns' and Mothers' Health Protection Act of 1996**

Notwithstanding anything in this Plan or the Schedule of Benefits to the contrary, in accordance with the Newborns' and Mothers' Health Protection Act, the Plan shall not restrict any inpatient hospital confinement in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section or require that a provider obtain authorization from the Plan for prescribing a confinement not in excess of the above time periods. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or the newborn earlier than 48 hours (or 96 hours as applicable).

### **Reconstructive Surgery Following Mastectomy**

If a Member is receiving benefits under the Plan in connection with a mastectomy and if the Member elects breast reconstruction in connection with such mastectomy, the Plan shall cover:

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

in a manner determined in consultation with the attending Physician and the Member.

The Plan shall not (a) deny any Member eligibility or continued eligibility to enroll or to renew coverage under the terms of the Plan solely for the purpose of avoiding the coverage provided under this section or (b) penalize or otherwise reduce or limit the reimbursement of an attending Provider, or provide incentives (monetary or otherwise) to an attending Provider, to induce the provider to provide care to a Member in a manner inconsistent with the coverage provided in this section.

### **Qualified Medical Child Support Orders**

The Plan shall provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order received by the Plan. If the Plan receives a medical child support order, the Plan Administrator shall promptly notify the Member, and each child of the Member identified in the order, of the receipt of such order and the Plan's procedures for determining whether the order is a Qualified Medical Child Support Order. Within a reasonable time after receipt of such order, the Plan Administrator shall determine whether the order is a qualified medical child support order and notify the Member and each child involved of the determination. The Plan Administrator shall establish written procedures in accordance with Section 609 of

ERISA to determine whether a medical child support order received by the Plan is a Qualified Medical Child Support Order under ERISA.

### **Nonalienation and Assignment**

Except as provided under a Qualified Medical Child Support Order, no benefit under the Plan prior to actual receipt thereof by a Member shall be subject to any debt, liability, contract, engagement, or tort of any Member, nor subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process. Notwithstanding the preceding sentence, the Plan shall pay any benefits under the Plan to the Member unless the Member shall assign benefits to a hospital, physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment, however, shall be binding on the Plan unless the Plan Administrator is notified in writing of such assignment prior to payment hereunder.

### **Privacy of Protected Health Information**

#### **Purpose**

This Section permits the Company to receive Protected Health Information from the Plan or a Business Associate in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations.

#### **1. Plan Sponsor's Certification of Compliance.**

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Documents have been amended to incorporate this amendment and agrees to abide by this amendment.

#### **2. Purpose of Disclosure to Plan Sponsor.**

- a. The Plan and any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out administration functions for the Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Plan Sponsor of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this amendment.
- b. Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Participants.
- c. Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information

to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

### **3. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information.**

- a. The Plan Sponsor will neither use nor further disclose Plan Participants' Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.
- b. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Plan Participants' Protected Health Information agrees to the restrictions and conditions of the Plan Documents, including this amendment, with respect to Plan Participants' Protected Health Information.
- c. The Plan Sponsor will not use or disclose Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- d. The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this amendment promptly upon learning of such inconsistent use or disclosure.
- e. The Plan Sponsor will make Protected Health Information available to the Plan Participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.
- f. The Plan Sponsor will make Plan Participants' Protected Health Information available for amendment, and will on notice amend Plan Participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.
- g. The Plan Sponsor will track disclosures it may make of Plan Participants' Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.
- h. The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of Plan Participants' Protected Health Information, available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64, Part E "Privacy of Individually Identifiable Health Information."
- i. The Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Plan Participant Protected Health Information, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the

Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant Protected Health Information, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Plan Participant Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

#### **4. Adequate Separation Between the Plan Sponsor and the Plan.**

- a. To permit the Plan Sponsor to carry out its responsibilities for administration of the Plan, the following employees or classes of employees or other workforce members under the control of the Plan Sponsor may be given access to Plan Participants' Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:

*CBS Contact Center Staff, CBS H&W Benefits Staff, H&W Benefits Strategy, IT staff assisting with Health Plan data transmission*

This list includes every employee or class of employees or other workforce members under the control of the Plan Sponsor who may receive Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

- b. The employees, classes of employees or other workforce members identified in paragraph 4(a) of the amendment will have access to Plan Participants' Protected Health Information only to perform the Plan administration functions that the Plan Sponsor provides for the Plan.

The employees, classes of employees or other workforce members identified in paragraph 4(a) of this amendment will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this amendment to the Plan Documents. Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(d) of this amendment, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

#### **Plan Information Practices Notice**

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Claims Administrator's business activities.

- The Claims Administrator may collect personal information about a Member from persons or entities other than the Member.
- The Claims Administrator may disclose Member information to persons or entities outside of the Administrator and the Company without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Claims Administrator.
- The Claims Administrator takes reasonable precautions to protect Member information in its possession, including the use of restricted computer access.

A Member may request a more detailed notice regarding the types of personal information that may be collected by the Plan and the types of disclosures and the circumstances under which such disclosures may be made without prior authorization by submitting a written request to customer services.

### **Member's Cooperation**

Each Member shall complete and submit to the Plan and the Claims Administrator such consents, releases, assignments and other documents as may be requested by the Plan or the Claims Administrator in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

### **Conversion Rights**

If you or your eligible Dependents do not elect COBRA, your coverage will end. You cannot convert the coverage to an individual policy.

### **Plan Funding**

Benefits under the Plan are paid through Company assets, in such amounts as shall be determined from time to time by the Company, to be held, managed, invested, and distributed in accordance with the provisions of the Plan. All such contributions may consist of Company contributions or Member contributions or both, in an amount determined by the Company. Certain Member contributions shall be treated as Company contributions in accordance with the Cummins Inc. Cafeteria Plan.

### **Other Provisions**

The following provisions shall apply to the Plan:

- The Company and/or its designee, may from time to time consult with counsel, who may be counsel for the Company, and shall be fully protected in acting upon the advice of such counsel.
- Any action by the Company pursuant to any of the provisions of the Plan shall be evidenced by resolution of its governing body, and the Company shall be fully protected in acting in accordance with such resolution so certified to it. All orders, requests, and instructions to an Employee by the Company, the Claims Administrator, or any duly authorized representative, shall be in writing and the

Company shall act and shall be fully protected in acting in accordance with such orders, requests, and instructions.

- If an audit of the Plan is required under ERISA for any Plan Year, the Company shall engage an independent qualified public accountant. Such audit shall be conducted in accordance with the requirements of Section 103 of ERISA.
- Each fiduciary of the Plan, unless exempted under ERISA, shall be bonded in an amount not less than ten percent (10%) of the amount of assets of the Plan handled by such fiduciary; provided, however, such bond shall not be less than One Thousand Dollars (\$1,000) and need not be for more than Five Hundred Thousand Dollars (\$500,000). The expense of such bond shall be paid from the assets of the Plan unless paid by the Company.
- Any payments to any Member shall, to the extent thereof, be in full satisfaction of the claim of such Member being paid thereby and the Company may condition payment thereof on the delivery by the Member of the duly executed receipt and release in such form as may be determined by the Company.
- If the Company is made a party to any legal action regarding the Plan, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the Company in connection with such proceeding shall be paid from the assets of the Plan unless paid by the Company.
- The Company shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the Company to be genuine or to be executed or sent by an authorized person.
- Any material misrepresentation on the part of the Member in making application for coverage, or reclassification of coverage, or in applying for and/or for obtaining benefits under the Plan, shall render the coverage null and void *ab initio*.
- If the Company, Plan Administrator, or Claims Administrator makes any payment that according to the terms of the Plan should not have been made, it may recover that incorrect payment, whether or not it was made due to the Company's, Plan Administrator's, or Claims Administrator's, own error, from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made directly to a Member, the Company, the Claims Administrator, or Plan Administrator may deduct it when making future payments directly to that Member.
- The Plan shall be construed, enforced, and administered and the validity thereof determined in accordance with ERISA and in accordance with the laws of the State of Indiana when such laws are not inconsistent with ERISA.
- If, in the opinion of the Plan Administrator, a valid release cannot be rendered by a Member for the payment of any benefit payable, such payment may be made directly to a Provider, or to the guardian or conservator, or the parents of a minor child, or to an individual or individuals who have custody or provide care and



principal support of the Member. In the event of the death of a Member, payment shall be made by the Plan Administrator to the duly qualified and acting personal representative of that Member's estate (or, if there is no such personal representative, to the person or persons entitled to such payments). Any payment made by the Plan Administrator in good faith pursuant to this provision shall fully discharge all liability to the extent of such payment.

- Any notice given under the Plan shall be sufficient if given to the Plan Administrator, when addressed to it at its office; or if given to a Member, when addressed to the Member at his or her address as it appears on the records of the Plan Administrator.

## **ERISA Rights**

As a participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA entitles you to:

- examine, at the Plan Administrator's office and other specified locations, including work sites and union halls, if applicable, without charge, all Plan documents governing the Plan. These documents may include insurance contracts, collective bargaining agreements and the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain, after sending a written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. You may be asked to pay a fee for the copies.
- receive a written summary of the Plan's annual financial report. The Plan Administrator is required by law to provide each Covered Employee with a copy of this summary annual report.
- continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Plan and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a

Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties on the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the best interest of you and other Plan participants and beneficiaries. No one, including the Company, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, before you file suit, you must first complete all of the claims procedures outlined in the **BENEFITS COMPLAINT AND APPEALS PROCEDURE** and **FILING A CLAIM** sections. If you do not follow these claims procedures accordingly, you will have no right to review and no right to bring action, at law or in equity, in any court, and the denial of the claim will become final and binding.

In addition, if you disagree with the Plan's decision or lack of decision about the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and a fee if, for example, it finds your claim is frivolous.

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

## **General Information About the Plan**

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### **Plan Administrator/Plan Sponsor**

Cummins Inc.  
500 Jackson Street  
Columbus, IN 47201  
Phone: (812) 377-5000

### **Plan name**

Cummins Inc. U.S. Group Medical PPO Plan portion of the Cummins Inc. and Affiliates Group Insurance Plan

### **Employer Identification Number (EIN)**

The EIN is 35-0257090.

### **Plan number**

The plan number is 510.

### **Plan Year**

The Plan Year is January 1 through December 31.

### **Source of Benefits Funding**

The Plan Sponsor and the employees pay the cost of this Plan. This Plan is self-funded.

### **Agent for Services of Legal Process**

Cummins Inc.  
Attn: General Counsel  
Post Office Box 3005  
500 Jackson Street  
Columbus, IN 47201  
Phone: (812) 377-5000

## **Claims Administrators**

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### **Medical**

Anthem Blue Cross Blue Shield  
220 Virginia Ave  
Indianapolis, IN 46204  
Phone: (866) 251-1779

### **Prescription Drug**

Express Scripts  
P.O. Box 14711  
Lexington, KY 40512  
Phone: (866) 544-6968  
Website: [www.express-scripts.com](http://www.express-scripts.com)

### **Mail Order Prescription Drug Provider**

Express Scripts  
P.O. Box 747000  
Cincinnati, OH 45274-7000  
Phone: (866) 544-6968  
Website: [www.express-scripts.com](http://www.express-scripts.com)

### **COBRA Administrator**

CBS Benefits Contact Center  
2931 Elm Hill Pike  
Nashville, TN 37214  
(877) 377-4357

## **Contacts**

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### **For Medical Claim Forms**

Anthem Blue Cross Blue Shield  
Attn: Member Submit Claims  
P.O. Box 105187  
Atlanta, GA 30348  
Phone: (866) 251-1779  
Website: [www.anthem.com](http://www.anthem.com)

### **For COBRA and Domestic Partner Forms**

CBS Benefits Contact Center  
2931 Elm Hill Pike  
Nashville, TN 37214  
Phone: (877) 377-4357

### **For a Copy of In-Network Providers**

Phone: (866) 251-1779  
Website: [www.anthem.com](http://www.anthem.com)

### **Getting Precertification for Non-Emergency Services**

Phone: (866) 251-1779  
Website: [www.anthem.com](http://www.anthem.com)

### **For Sending a Completed Medical Claim**

Anthem Blue Cross Blue Shield processes claims at service centers in the state where medical service is rendered. Please contact Anthem Blue Cross Blue Shield at (866) 251-1779 for the address of the service center in your state.

### **For Sending Completed Breast Pump Claims**

Anthem Blue Cross Blue Shield  
Attn: Claims  
220 Virginia Ave  
Mailpoint IN0203-C478  
Indianapolis, IN 46204  
(866) 251-1779

### **For Sending Completed Vision Claims**

Blue View Vision  
Attn: OON Claims  
P.O. Box 8504  
Mason, OH 45040  
(866) 293-7373

### **For Appealing a Medical Claim**

Anthem Blue Cross Blue Shield Appeals

P.O. Box 105568  
Atlanta, GA 30348-5568  
\*All appeals must be in writing

**Prescription Drug Network Provider**

Express Scripts Health Solutions, Inc.  
P.O. Box 14711  
Lexington, KY 40512  
Phone: (866) 544-6968  
Website: [www.express-scripts.com](http://www.express-scripts.com)

**Mail-order program**

Express Scripts  
P.O. Box 747000  
Cincinnati, OH 45274-7000  
Phone: (866) 544-6968  
Website: [www.express-scripts.com](http://www.express-scripts.com)

**Specialty Pharmacy Program**

Express Scripts  
P.O. Box 747000  
Cincinnati, OH 45274-7000  
Phone: 1-800-501-7210 (8am-8pm EST Mon-Fri)  
Website: [www.express-scripts.com](http://www.express-scripts.com)